State of Kansas Employees
Health Care Benefits

HEALTH MAINTENANCE ORGANIZATION (HMO)

CERTICATE OF COVERAGE

NOTICE

THIS CERTIFICATE OF COVERAGE AND ALL ATTACHMENTS SHOULD BE READ IN THEIR ENTIRETY

This HMO has restrictions regarding which Physicians or other health care Providers an HMO Plan Member may use. Please consult Your Member materials for more details. If you have any additional questions, please write or call us at:

Coventry Health Care of Kansas, Inc.
8320 Ward Parkway
Kansas City, MO 64114
(800) 969-3343
www.chckansas.com

8301 East 21st Street North, Suite 300
Wichita, Kansas 67206
(800) 320-0697

Welcome to Coventry Health Care of Kansas, Inc.!

We are extremely pleased to have you enrolling in our Plan and look forward to serving You. We have built a strong network of area Physicians, Hospitals, and other providers to offer a broad range of services for Your medical needs.

As a Coventry Health Care of Kansas, Inc. Member, it is important that You understand the way Your Plan operates. This Certificate of Coverage contains the information You need to know about Your Coverage with us.

Please take a few minutes to read these materials and to make Your Covered family members aware of the provisions of Your Coverage. Our Customer Service Department is available to answer any questions You may have about Your Coverage. You can reach them at the number listed in the Schedule of Important Numbers Monday through Thursday, 8:00 a.m. to 6:00 p.m., Friday, 8:00 a.m. to 5:00 p.m. Central Standard Time. You can also check the Plan's website at www.chckansas.com at any time for additional information.

We look forward to serving You and Your family.

Sincerely,

Jan Stallmeyer

President and Chief Executive Officer

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Coventry Health Care of Kansas, Inc.

Certificate of Coverage

The Agreement between **Coventry Health Care of Kansas, Inc.** (hereafter called the Plan) and You and between the Plan and Your Dependents as Members of the Plan is made up of:

- This Certificate of Coverage (COC) and Amendments;
- The Enrollment record from the Group;
- The Group Master Contract; and
- Schedule of Benefits.

This Agreement begins on the date defined in the Group Master Contract. It continues, until replaced or terminated, while its conditions are met. You are subject to all terms, conditions, limitations, and exclusions in this Agreement and to all the rules and regulations of the Plan. By paying Premiums or having Premiums paid on Your behalf, You accept the provisions of this Agreement. The Agreement constitutes the entire contract between the parties and that, to be valid, any change in the Agreement must be approved by an officer of the Plan and attached to the affected Agreement an that no agent or representative has the authority to change the Agreement or waive any of the provisions.

THIS AGREEMENT SHOULD BE READ IN ITS ENTIRETY. By carefully reading this Agreement and understanding Your relationship to the Plan, You can be an informed participant. You should keep this COC in a safe place for Your future reference. Many of the provisions of this Agreement are interrelated; therefore, reading just one or two provisions may give You a misleading impression. Many words used in this Agreement will appear capitalized because they have special meaning and are defined for You in Section 1. By using these definitions, You will have a clearer understanding of Your Coverage. From time to time, the Agreement may be amended. When that occurs, the Plan will provide an Amendment or new COC to You for this Agreement.

You may examine a copy of this COC on the Group web site. You may examine a copy of the Group Master Contract, Amendments, and Schedule of Benefits at the office of the Employer Group during regular business hours.

The Plan is responsible for making benefit determinations in accordance with the Group Master Contract, this COC and the Plan's agreements with Participating Providers. The Plan does not and will not make medical treatment decisions. Only Providers may make such decisions after meeting with You. If the Plan denies a claim or Authorization for payment of a recommended service, the treating Provider may request reconsideration of that decision through the Plan's provider dispute resolution procedure. Regardless of whether the Provider requests reconsideration of the decision through the dispute resolution procedure, You may request reconsideration of that decision through the Plan's Member Complaint and Grievance Procedure described in this COC. The Plan's Provider dispute resolution procedure and the Plan's Member Complaint and Grievance Procedure are separate and independent of each other.

Disclaimer

It is the treating physician and the patient not the Plan or the employer, who determines the course of medical treatment. Whether or not the Plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be.

SECTION 1
DEFINITIONS

Any capitalized terms listed in this Section shall have the meaning set forth below whenever the capitalized term is used in this Agreement.

1.1 Activities of Daily Living

Activities usually done during a normal day including but not limited to bathing, dressing, eating, maintaining continence, toileting, transferring from bed to chair, taking medications and mobility.

1.2 Acute

Refers to an Illness or Injury that is both severe and of recent onset.

1.3 Administrative Appeal

An Appeal of a decision that has not been issued for medical necessity or medical appropriateness, but is administrative in nature, for example, appealing a Copayment, Coinsurance, or exclusion associated with a Covered Service.

1.4 Adverse Benefit Determination

A denial of a request for service or a failure to provide or make payment in whole or in part for a benefit. An Adverse Benefit Determination may be based in whole or in part on a medical judgment and may also include:

- Any reduction or termination of a benefit;
- The failure to cover services because they are determined to be Experimental or Investigational;
- The failure to cover services because they are determined not to be Medically Necessary or inappropriate;
- The failure to cover services because they are Cosmetic;
- The failure to cover services because they involve out of area referrals;
- The failure, reduction, or termination regarding the availability and/or delivery of health care services;
- The failure, reduction, or termination regarding claims payment, handling or reimbursement for health care services; and/or
- The failure, reduction, or termination regarding terms of the contractual relationship between Member and the Plan.

1.5 Agreement

The Certificate of Coverage (COC) and Amendments, the Enrollment record from the Group, the Group Master Contract, and the Schedule of Benefits together form the Agreement.

1.6 Alternate Facility

A duly-licensed non-Hospital health care facility or an attached facility designated as such by a Hospital which provides one or more of the following services on an outpatient basis pursuant to the law of the jurisdiction in which treatment is received, including without limitation:

- Scheduled surgical services;
- Emergency services;

- Urgent Care Services;
- Prescheduled rehabilitative services;
- Laboratory or diagnostic services;
- Inpatient or outpatient Mental Health services or Substance Abuse services.

1.7 Alternate Recipient

The child or children identified in the medical child support order as being eligible to receive health care Coverage pursuant to the medical child support order.

1.8 Amendment

Any attached written description of additional or alternative provisions to the Agreement and/or this COC. Amendments are effective only when Authorized in writing by the Plan, Group and the Kansas Insurance Department and are subject to all conditions, limitations and exclusions of the Agreement except for those which are specifically amended.

1.9 Ancillary Provider

A Provider who is not licensed as a Physician or a Hospital.

1.10 Appeal

An Appeal is a request by You or Your Authorized Representative for re-consideration of an Adverse Benefit Determination of a service request or benefit that You believe You are entitled to receive.

1.11 Authorization/Prior Authorization

The Plan has given approval for payment for Covered Services to be performed. Authorization does not guarantee payment if You are not eligible for Covered Services at the time the service is provided.

1.12 Authorized Representative

An Authorized Representative is an individual authorized in writing or verbally by You or by state law to act on Your behalf in requesting a health care service, obtaining claim payment or during the Appeal process. A Provider may act on Your behalf with Your expressed consent, or without Your expressed consent when it involves an Urgent Care claim or Appeal. An Authorized Representative does not constitute designation of a personal representative for Health Insurance Portability and Accountability Act (HIPAA) privacy purposes.

1.13 Basic Health Services

Services which a Member may reasonably require in order to be maintained in good health, including as a minimum, inpatient Hospital, Physician, outpatient services, and Emergency services that are Covered under this COC.

1.14 Biologically Based Mental Illness means the following:

- Schizophrenia, schizo affective disorder, schizophreniform disorder, brief reactive psychosis, paranoid or delusional disorder, atypical psychosis;
- Major affective disorders (bipolar and major depression), cyclothymic and dysthymic disorders;
- Obsessive compulsive disorder;
- Panic disorder;
- Pervasive developmental disorder, including autism;
- Attention deficit disorder and attention deficit hyperactive disorder.

1.15 Calendar Year

The period of time from January 1 through December 31 inclusive. This is the period during which the total amount of annual benefits under Your Coverage is calculated.

1.16 Calendar Year Benefit Maximum

A maximum dollar amount, or maximum number of days, visits or sessions for which Covered Services are provided for a Member in any one Calendar Year. Once a Calendar Year Benefit Maximum is met, no more Covered Services will be provided during the same Calendar Year.

1.17 Certificate of Coverage (COC)

This booklet and any Amendments attached hereto.

1.18 Certificate of Creditable Coverage

The certificate that documents the individual's Creditable Coverage. Under the terms of HIPAA, the written certification must be furnished automatically to individuals when normal Coverage terminates and again when COBRA Coverage terminates. A certificate must also be furnished upon written request made within 24 months after plan Coverage terminates.

1.19 Chiropractic Services

Services provided by a duly-licensed Doctor of Chiropractic Medicine, including but not limited to subluxation and manipulation.

1.20 Chronic Condition

A health condition that is continuous or persistent over an extended period of time.

1.21 COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

1.22 Coinsurance

Cost-sharing arrangement in which the Member pays a specified percentage of the cost for a Covered Service.

1.23 Coinsurance Maximum

The annual limit of a Member's payments for coinsurance on Covered Services, as specified in the Schedule of Benefits.

1.24 Complaint

Any dissatisfaction expressed by You or Your Authorized Representative regarding a Plan issue (e.g., a Complaint concerning long wait times at a Physician's office).

1.25 Confinement and Confined

An uninterrupted stay following formal admission to a Hospital, an Alternate Facility or Participating Skilled Nursing Facility.

1.26 Copayment

Cost-sharing arrangement in which a Member pays a specified dollar amount as their share of the cost for a Covered Service.

1.27 Cosmetic Services and Surgery

Services performed to reshape structures of the body in order to alter appearance, to alter the aging process, or when performed primarily for psychological purposes.

1.28 Coverage or Covered

The entitlement by a Member to Covered Services under the COC, subject to the terms, conditions, limitations and exclusions of the COC, including the following conditions: (a) services must be provided when the COC is in effect; and (b) services must be provided prior to the date that any of the termination conditions listed in this COC occur; and (c) services must be provided only when the recipient is a Member and meets all eligibility requirements specified in the COC; and (d) services must be Medically Necessary and appropriate.

1.29 Covered Services

The services or supplies provided to You for which the Plan will make payment, as described in the Agreement.

1.30 Creditable Coverage

Coverage of an individual through one or more of the following:

- A group health plan;
- A health maintenance organization (HMO);
- An individual health insurance policy;
- Medicare;
- Medicaid;
- Military Health;
- A medical program of the Indian Health Service or of a Tribal Organization;
- State health pool;
- Federal Employee Health Benefit Program;
- Public health plan; or
- Peace Corps Plan.

1.31 Custodial and Maintenance Care

Care is considered custodial or maintenance when it is primarily for the purpose of helping the Member with Activities of Daily Living or meeting personal needs and can be provided safely and reasonably by people without professional skills or training. This term includes such other care that is provided to a Member who, in the opinion of the Medical Director, has reached his or her maximum level of recovery. This term also includes services to an institutionalized Member, who cannot reasonably be expected to live outside of an institution. Examples of Custodial Care include, but are not limited to, respite care and home care which is or which could be provided by family members or private duty caregivers.

1.32 Dependent

Any member of a Subscriber's family who meets the eligibility requirements and who is properly enrolled for Coverage under the Agreement and on whose behalf Premiums are paid by You or the Employer Group.

1.33 Designated Transplant Network Facility

A Hospital appointed as a Designated Transplant Network Facility by the Plan, to render Medically Necessary and medically appropriate services for Covered transplants. A Designated Transplant Network Facility may or may not be located within the Plan's Service Area. You may request a listing of Designated Transplant Network Facilities from the Customer Service Department listed in the Schedule of Important Numbers. The list may be amended from time to time.

1.34 Designated Transplant Network Physician

A Physician appointed as a Designated Transplant Network Physician by the Plan, who has entered into an agreement with a Designated Transplant Network Facility to render Medically Necessary and medically appropriate services for Covered transplants.

1.35 Durable Medical Equipment

Medical equipment Covered under this COC, which can withstand repeated use and is not disposable, is used to serve a medical purpose, is generally not useful to a person in the absence of an Illness or Injury, and is appropriate for use in the home. Medically Necessary, non-disposable accessories that are commonly associated with the use of a Covered piece of Durable Medical Equipment will be considered Durable Medical Equipment.

1.36 Effective Date

The date of Coverage as determined by the Employer Group and agreed to by the Plan, as set forth in the Group Master Contract.

1.37 Eligible Employee

An individual employed by the Employer Group who meets all the eligibility requirements specified in the Agreement including, but not limited to, this COC, and the Group's eligibility rules as documented in the Group Master Contract.

1.38 Eligible Expenses

Charges for Covered Services, incurred while the Agreement is in effect.

1.39 Emergency Medical Condition and Medical Emergency

The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate medical care is required. These services may include, but shall not be limited to conditions that:

- Place the Member's health in significant jeopardy;
- Seriously impair a bodily function;
- Serious dysfunction of a body organ or part;
- Inadequately controlled pain; or
- With respect to a pregnant woman who is having contractions:
  - That there is inadequate time to effect a safe transfer to another Hospital before delivery; or
  - That the transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

Some examples of an Emergency Medical Condition include, but are not limited to:

- Broken bone;
- Chest pain;
- Seizures or convulsions;
- Severe or unusual bleeding;
- Severe burns;
- Suspected poisoning;
- Trouble breathing;
- Vaginal bleeding during pregnancy.

The Member may seek medical attention from a Hospital, Physician's office or some other Emergency facility.

1.40 Emergency Services

Generally, Eligible Expenses for Emergency Services are the charges for the services provided during the course of the Emergency, and when Medically Necessary for stabilization and initiation of treatment. The Emergency Services must be provided by or under the direction of an appropriate medical provider acting within the scope of their license, and are subject to the exclusions and other provisions set out in this COC.

1.41 Employer Group

The employer or other legally constituted group with whom the Group Master Contract is made.

1.42 Employee Enrollment/Change Form

Your application for enrollment in the Plan.

1.43 Experimental or Investigational

A health product or service is deemed Experimental or Investigational if one or more of the following conditions are met:

- Any drug not approved for use by the Federal Food and Drug Administration (FDA); any drug that is classified as an Investigational New Drug (IND) by the FDA; any drug that is proposed for off-label prescribing, except for cancer treatment. As used herein, off-label prescribing means prescribing prescription drugs for treatments other than those stated in the labeling approved by the FDA.
- Any health product or service that is subject to Investigational Review Board (IRB) review or approval;

  Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations, except as specifically covered.
- Any health product or service whose effectiveness is unproven or is not considered standard treatment by the medical community, based on clinical evidence reported by Peer-Reviewed Medical Literature and by generally recognized academic experts.

1.44 FDA

Federal Food and Drug Administration.

1.45 Group Master Contract (GMC)

The agreement between the Employer Group and the Plan that states the agreed upon contractual rights and obligations of the Plan, the Group, and Members.

1.46 Group Effective Date

The date that is specified in the Group Master Contract as the Effective Date of this Agreement.

1.47 Group Enrollment Period

The period of time occurring at least once annually during which time any Eligible Employee may enroll with the Plan.

1.48 Home Health Agency

An organization that meets all of these tests: (a) its main function is to provide home health care services and supplies; (b) it is federally certified as a home health care agency; and (c) it is licensed by the state in which it is located, if licensing is required.

1.49 Home Health Care Services

Skilled nursing care and intermittent home health aide services provided to the homebound through a home health care agency, including physical therapy, speech therapy, occupational therapy, and medical supplies for the treatment of an illness or injury.

1.50 Hospital

An institution, operated pursuant to law, which: (a) is primarily engaged in providing services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of one or more Physicians; and (b) has twenty-four (24) hour nursing services on duty or on call. For the purpose of this definition, a facility that is primarily a place for rest, Custodial Care or care of the aged, a nursing home, convalescent home, or similar institution is not a Hospital.

1.51 Illness

Physical ailment, disease, or pregnancy. For the purpose of this definition, the term Illness does not apply to Mental Illness or Substance Abuse.

1.52 IND

Investigational New Drug.

1.53 Infertility

Any medical condition causing the inability or diminished ability to reproduce.

1.54 Infertility Services

Those services including confinement, treatment or services related to the restoration of fertility or the promotion of conception.

1.55 Injury

Bodily damage, other than Illness, including all related conditions and recurrent symptoms.

1.56 Inquiry

Any question from You or Your Authorized Representative that is not a Pre-Service Appeal, a Post-Service Appeal or an Urgent Care Appeal, or Complaint.

1.57 Institutional Review Board (IRB)

A university or Participating Hospital panel composed of faculty and researchers that evaluates experimental and investigational procedures.

1.58 Late Enrollees

Shall mean individuals who fail to enroll with the Plan for Coverage under the Agreement during the initial enrollment period when they first become eligible for Coverage as described in the Enrollment and Eligibility Section of this COC. This term does not include individuals who enroll under a Special Enrollment Period; an employee of an employer which offers multiple health benefit plans, who elects a different health benefit plan during an open enrollment period; or a spouse or minor child who is eligible for Coverage due to a court order.

1.59 Lifetime

Lifetime refers to the life of the member without regard to health insurance carrier.

1.60 Limiting Age

The maximum age a non-Spouse Dependent can be to maintain eligibility under the terms of the Plan, and as defined by the Group's eligibility rules as documented in the Group

Master Contract.

1.61 Maternity Services

Includes prenatal and postnatal care, childbirth, and any complications associated with pregnancy.

1.62 Maximum Lifetime Benefit

The Maximum Lifetime Benefit is the maximum amount payable by the Plan per Member, if applicable, and listed in the Schedule of Benefits.

1.63 Medical Director

The Physician specified by the Plan, or his or her designee, who is responsible for medical oversight programs, including but not limited to Authorization/Prior Authorization programs.

1.64 Medically Necessary/Medical Necessity

Medically Necessary means those services, supplies, equipment and facility charges that are not expressly excluded under this Agreement and are:

- Medically appropriate, so that expected health benefits (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks;
- Necessary to treat an illness or injury, expected to result in improvement to the condition, and required for a reason other than improving appearance;
- Rendered in the most cost-efficient manner and setting appropriate for the delivery of the service;
- Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are generally accepted as national authorities on the services, supplies, equipment or facilities for which Coverage is requested;
- Consistent with the diagnosis of the condition at issue;
- Required for reasons other than Your comfort or the comfort and convenience of Your Physician; and
- Not Experimental or Investigational as determined by the Plan under the Plan's Experimental Procedures Determination Policy.

1.65 Medical Necessity Appeal

An Appeal of a determination by the Plan or its designated utilization review organization that is based in whole or in part on a medical judgment that includes an admission, availability of care, continued stay or other service which has been reviewed and, based on the information provided, does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and payment for the service is denied, reduced or terminated.

1.66 Medicare

Part A, Part B and Part D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

1.67 Member

Any Subscriber or Dependent or Qualified Beneficiary (as that term is defined under COBRA) who enrolled for Coverage under this Agreement in accordance with its terms and conditions.

1.68 Mental Health and Substance Abuse Designee

The organization, entity or individual that provides or arranges Covered Mental Health and Substance Abuse services under contract to the Plan.

1.69 Mental Illness or Mental Health

Those conditions classified as "mental disorders" in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders but not including mental retardation.

1.70 NIH

National Institutes of Health.

1.71 Non-Participating Provider

A Provider who has no direct or indirect written agreement with the Plan to provide services to Members.

1.72 Officer

The person holding the office of President and/or CEO or his or her designee.

1.73 Orthotic Appliances

Orthotic Appliances correct or support a defect of a body form or function.

1.74 Participating Provider

A Provider who has a contractual arrangement with the Plan for the provision of Covered Services to the Members.

1.75 Peer-Reviewed Medical Literature

A scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in two major American medical journals. Peer-Reviewed Medical Literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company, a device manufacturing company, or health vendor.

1.76 Physician/Practitioner

Means anyone qualified and licensed to practice medicine and surgery by the state in which services are rendered who has the Degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) Physician also means Doctors of Dentistry and Podiatry when they are acting within the scope of their license.

By use of this term, the Plan recognizes and accepts, to the extent of the Plan's obligation under the Agreement, other practitioners of medical care and treatment when the services performed are within the lawful scope of the practitioner's license and are provided pursuant to applicable laws.

1.77 Plan

Coventry Health Care of Kansas, Inc.

1.78 Post-Service Appeal

An appeal for which an Adverse Benefit Determination has been rendered for a service that has already been provided.

1.79 Pre-Service Appeal

An appeal for which an Adverse Benefit Determination has been rendered for a service that has not yet been provided and requires Prior Authorization.

1.80 Premium

The monthly fee required from each Employer Group on behalf of each Subscriber and each Enrolled Dependent in accordance with the terms of the Agreement.

1.81 Primary Care Physician (PCP)

The Participating Provider who practices in the fields of Internal Medicine, Family Practice, General Practice, or Pediatrics who is designated as a PCP by the Plan and who is responsible for providing, or referring for, care to Members who have chosen and have been accepted as patients by that Physician.

1.82 Prosthetic Devices

Prosthetic Devices aid body functioning or replace a limb or body part. Prosthetic Devices can be either internally or externally placed.

1.83 Provider

A Physician, Hospital, or Ancillary Provider or other duly licensed health care facility or practitioner, certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received.

1.84 Provider Directory

A listing of Participating Providers either electronic or paper. Please be aware that the information in the Provider Directory is subject to change and will be updated periodically.

1.85 Qualified Medical Child Support Order (QMCSO)

An issued order, judgment, decree or settlement agreement by a court of competent jurisdiction or issued through an administrative process established under State law and has the force and effect of law under applicable State law that requires a non-custodial parent to provide medical Coverage for his/her child who might not otherwise be eligible for Coverage. A qualified order includes information regarding: 1) The Member's name and address; 2) The name and last known mailing address of the alternate recipient; 3) The name of the Plan the child will be Covered by; 4) A reasonable description of the type and scope of health Coverage provided under the Plan; 5) The period of time to which the order applies; and 6) The order must be signed by the Judge, Commissioner or Magistrate.

Contact Customer Service if You would like to see a complete copy of the procedures for determining whether an order constitutes a QMCSO.

1.86 Reconstructive Surgery

Surgery which is incidental to an Injury, Illness or congenital anomaly when the primary purpose is to restore normal physiological functioning of the involved part of the body. (A congenital anomaly is a defective development or formation of a part of the body, when such defect is determined by the treating Physician to have been present at the time of birth.) The definition of Reconstructive Surgery includes the following: reconstructive surgery following a mastectomy, including on the opposite breast to restore symmetry and Prosthetic Devices/implants or reduction mammoplasty; and reconstructive surgery for a Covered newborn.

1.87 Self-Injectables

Injectable Prescription Drugs as specified in the Plan's formulary list, that are commonly and customarily administered by the Member according to clinical guidelines used by the Plan or the prescription drug program of the Group.

1.88 Semi-private Accommodations

A room with two (2) or more beds in a Hospital. The difference in cost between Semi-private Accommodations and private accommodations is Covered only when private accommodations are Medically Necessary.

1.89 Service Area

The geographic area served by the Plan and approved by the State Department of Insurance. The Plan's Service Area is subject to change from time to time. Please refer to Section 12 for a description of the Service Area.

1.90 Skilled Nursing Facility (SNF)

A facility certified by Medicare to provide inpatient skilled nursing care, rehabilitation services or other related services. The term Skilled Nursing Facility does not include a convalescent nursing home, rest facility, or facility for the aged that furnishes primarily Custodial Care, including training in Activities of Daily Living.

1.91 Special Enrollment Period

The period after the regular Group Enrollment Period during which an individual is allowed to enroll for Coverage subject to the terms of this COC.

1.92 Specialty Care Physician/Specialist

A Physician who is not a Primary Care Physician and provides medical services to Members concentrated in a specific medical area of expertise.

1.93 Spouse

A Subscriber's legal Spouse as determined by the Group's eligibility rules.

1.94 Subscriber

The Eligible Employee or Retiree who meets all the requirements as set forth in this COC and the Group's eligibility rules as documented in the Group Master Contract, and who has elected the Plan's Coverage for himself/herself and any eligible Dependents through submission of an Employee Enrollment/Change record and for whom, or on whose behalf, Premiums have been received by the Plan.

1.95 Substance Abuse

The psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

1.96 Therapeutic Injections and Intravenous (IV) Infusions

Prescription medications given by injection or IV infusion (specifically excluding blood) by a duly-licensed Provider or injected by the Member.

1.97 Total Disability

Complete inability of the Member to perform all of the substantial and material duties of his or her regular occupation, or complete inability of the Member to engage in employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience. For an unemployed Dependent, Total Disability means complete inability of the Member to engage in most of the normal activities of a person of like age and gender. The disability, for Subscriber or Dependent, must require regular care and attendance by a Physician who is someone other than an immediate family member.

1.98 Urgent Care

A condition that requires prompt medical attention due to an unexpected Illness or Injury. These conditions may also constitute Emergencies in those situations that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe immediate medical care is required.

1.99 Urgent Care Appeal

An Appeal for which a requested service requires prior authorization, an Adverse Benefit Determination has been rendered, the requested service has not been provided, and the application of non-urgent care Appeal time frames could seriously jeopardize: (a) the life or health of the Member or the Member's unborn child; or (b) the Member's ability to regain maximum function. In determining whether an Appeal involves urgent care, the Plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

1.100 Utilization Review

A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, prior authorization, concurrent review, case management, and discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of Coverage.

1.101 We, Us or Our

Coventry Health Care of Kansas, Inc.

1.102 You or Your

A Member Covered under this COC.

SECTION 2
USING YOUR BENEFITS

2.1 Membership Identification (ID) Card

Every Member receives a membership ID card. Carry Your ID card with You at all times, and present it every time You request or receive services. The ID card is needed for Providers to bill the Plan for charges other than Copayments, Coinsurance, and non-Covered Services. If You do not show Your ID card, the Providers cannot identify You as a Member of the Plan, and You may receive a bill for services. If Your ID card is missing, lost, or stolen, contact the Plan's Customer Service Department at 800-969-3343 (outside Wichita) or 316-609-2555 (Wichita) or through the website at www.chckansas.com to obtain a replacement. This information is also listed on Your ID card and in the Schedule of Important Numbers. If Your Dependents are Covered, You will receive an additional ID card for each Covered Dependent. Possession and use of an ID card is not an entitlement to Coverage. Coverage is subject to verification of eligibility and all the terms, conditions, limitations and exclusions set out in the Agreement.

2.2 Your Primary Care Physician (PCP)

The role of the PCP is important to the coordination of Your care, and You are encouraged to contact Your PCP when medical care is needed. You and Your PCP will work together to maintain Your health, and Your PCP will provide or coordinate most of Your health care needs. This may include preventive services, obtaining Authorization of certain services, consultation with Specialists and other Providers, and Emergency Services. Some services must also be Prior Authorized by the Plan prior to the rendering of such services.

2.3 Selecting Your PCP

Members choose their PCP from the Provider Directory, a list of Participating Providers who practice in the following areas: Family Practice, General Practice, Internal Medicine and Pediatrics.

When selecting a PCP, You may wish to contact individual Provider offices for additional information such as specifics of a Physician's training and experience or office hours and policies. One PCP may be selected for the entire family, or each Dependent may select a different PCP. If You do not choose a PCP within thirty-one (31) days of enrollment or within thirty-one (31) days of being notified that Your PCP is no longer Participating with the Plan, one may be assigned to You.

2.4 Changing Your PCP

Should You wish to change Your PCP, You must first contact the Plan's Customer Service Department at the toll free number provided on your ID card, or by visiting the website as listed on the cover of the COC or Your ID card. The change will take effect the same day that You notify the Plan of the PCP change.

2.5 Obstetrics / Gynecological Services

A female Member has direct access to the services of a participating obstetrician, participating gynecologist or participating obstetrician/gynecologist of her choice within

the Provider network for Covered Services. These Covered Services may be limited to those services defined by the published recommendations of the accreditation council for graduate medical education for training an obstetrician, gynecologist or obstetrician/gynecologist, including but not limited to diagnosis, treatment and referral for such services.

2.6 Health Services Rendered by Participating Providers

A Member has access to the services of a participating provider of their choice within the Provider network for Covered Services, subject to the terms, conditions, exclusions and limitations of the Agreement. Coverage for services described in this COC and the Schedule of Benefits include services that (a) are Medically Necessary and (b) are provided by or under the direction of a Participating Provider and (c) are Authorized, if required, in advance on behalf of the Member. The telephone number for prior Authorization is listed on Your ID card and in The Schedule Of Important Telephone Numbers And Addresses, which is attached to this COC. Participating Providers are contractually obligated to file all claims for You.

In the event that specific services cannot be provided by or through a Participating Provider, You may be eligible for Coverage of Eligible Expenses for Medically Necessary services obtained through Non-Participating Providers if Authorized in advance through the Plan. A Member is entitled to benefits for services from a Non-Participating Provider only in the case of an Emergency or if the Plan determines that a particular Medically Necessary service is not available from a Participating Provider. When services are not available from a Participating Provider, the Plan shall make a referral to an appropriate Provider, pursuant to a treatment plan approved by the Plan in consultation with Your Physician(s), the Non-Participating Provider and the Member or the Member's designee. The Member will incur no additional cost beyond what the Member would otherwise pay for services received from a Participating Provider.

Coverage for services is subject to timely payment of the Premium required for Coverage under the Plan and payment of the Copayment specified for any service.

2.7 Prior Authorization

Prior Authorization is required for certain Covered Services as determined by the Plan, such services include Hospital Admissions and related services, selected outpatient procedures, any procedures received from a Non-Participating Provider and all transplants. It is the Participating Provider's responsibility to obtain the Prior Authorization for the Covered Services they provide. You are responsible for Prior Authorization whenever You seek Covered Services from a Non-Participating Provider. A list of current Prior Authorization procedures is available to You by contacting the Plan's Customer Service Department's telephone number listed on Your ID card or by visiting the Plan's website at www.chckansas.com.

Any new, additional or extended services not Covered under the original Authorization will be Covered only if a new Authorization is obtained. All services identified in this COC are subject to all of the terms, conditions, exclusions and limitations of the Plan.

If the Plan Prior Authorizes Covered Services, the Plan shall not subsequently retract the Authorization after the Covered Services have been received, or reduce payment unless: (1) Such Authorization is based on a material misrepresentation or omission about the Member's health condition or the cause of the health condition; or (2) the Plan terminates before the

health care services are provided; or (3) the Member's Coverage under the Plan terminates before the health care services are provided.

2.8 Second Opinion Policy

A Member may seek a second medical opinion or consultation from the Plan's Participating Providers at no additional cost to the Member beyond what he/she would otherwise pay for an initial medical opinion or consultation.

In the event the Plan does not employ or contract with another Physician with the expertise necessary to provide a second medical opinion, the Plan will arrange for a referral to a Provider with the necessary expertise. Any second opinion rendered will be at no greater cost to the Member beyond what he would otherwise pay for an initial medical opinion or consultation.

2.9 Standing Referral to a Specialist

A Member who needs ongoing care from a specialist may receive a standing referral to such specialist. If the Plan, or the PCP in consultation with the Medical Director of the Plan and an appropriate specialist, determines that such a standing referral is warranted, the Plan shall make such a referral to a specialist. Such referral shall be pursuant to a treatment plan approved by the Plan in consultation with the PCP, the specialist, and the Member or the Member's designee. Such treatment plan may limit the number of visits or the period during which such visits are Authorized and may require the specialist to provide the PCP with regular updates on the specialty care provided, as well as all necessary medical information.

2.10 Specialized Referral

A Member upon enrollment, or a Member upon diagnosis, with a life-threatening or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may receive a referral to a specialist with expertise in treating the life-threatening or degenerative and disabling disease or condition who shall be responsible for and capable of providing and coordinating the Member's primary and specialty care. If the Plan, or PCP in consultation with a Medical Director of the Plan and an appropriate specialist, determines that such a specialist would most appropriately coordinate the Member's care, the Plan shall refer the Member to such specialist. Such referral shall be pursuant to a treatment plan approved by the Plan, in consultation with the PCP if appropriate, the specialist, and the Member or the Member's designee. Such specialist shall be permitted to treat the Member without a referral from the Member's PCP and may authorize such referrals, procedures, tests and other medical services as the Member's PCP would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan. If the Plan refers a Member to a non-Participating Provider, services provided pursuant to the approved treatment plan shall be provided at no additional cost to the Member beyond what the Member would otherwise pay for services received within the network.

2.11 Referral to Specialty Care Center

A Member with a life-threatening or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may receive a referral to a specialty care center with expertise in treating the life-threatening or degenerative and disabling disease or condition. If the Plan, or the PCP or a specialist designated pursuant to this section, in consultation with a Medical Director of the Plan,

determines that the Member's care would most appropriately be provided by such a specialty care center, the Plan shall refer the Member to such center. Such referral shall be pursuant to a treatment plan developed by the specialty care center and approved by the Plan, in consultation with the PCP, if any, or a specialist designated pursuant to this section, and the Member or the Member's designee. For purposes of this section, a specialty care center shall mean only such centers as are accredited or designated by an agency of the State or Federal government, or by a voluntary national health organization as having special expertise in treating the life-threatening or degenerative and disabling disease or condition for which it is accredited or designated.

2.12 Referrals and Authorization

In the event You require a Specialist's services or Hospitalization, Your PCP will coordinate Your care. All care must be obtained from a Participating Provider unless specifically Authorized by the Plan in accordance with the Plan's policies and procedures.

If Your Physician feels that a Member needs to see a Physician or other medical Provider who does not Participate with the Plan, then **You must obtain Authorization from the Plan prior to receiving services from Non-Participating Providers.** The Plan's medical management staff will review the information and will notify Your Physician of the decision. If Your PCP refuses to provide a referral to a Participating Provider of Your choice, please call the Customer Service Department for assistance. Additionally, PCPs do not have the authority to independently bind the Plan to Coverage for medical services that are not Covered Services as described in this COC or mandated by state law. Questions regarding Coverage for services or Provider participation status should be directed to the Plan, not the Provider. To verify Coverage of services or Provider participation status, please contact the Customer Service Department.

2.13 Copayments and Coinsurance

You are responsible for paying Copayments to Participating Providers at the time of service. The Provider may bill You at a later time for the Coinsurance amounts that are Your responsibility under the terms of the Plan as determined by the contracted rates that have been established between the Plan and the Participating Providers. Specific Copayments, and Coinsurance amounts are listed in the Schedule of Benefits.

A Copayment is defined as a dollar amount, while Coinsurance is typically defined as a percentage of Eligible Expenses.

Coinsurance Maximum: A Coinsurance Maximum is the amount of covered expenses, which must be paid each Calendar Year by a Member before the payment percentage of the Plan increases. The individual Coinsurance Maximum applies separately to each Member. The family Coinsurance Maximum applies collectively to all Members in the same family. The Plan will pay 100% (except for Copayments and the charges excluded) for any covered family Member during the remainder of the Calendar Year.

2.14 Participating Provider Terminations

The Plan or a Participating Provider may end the relationship with the other party after having supplied notice under applicable law, therefore the Plan does not promise that any specific Participating Provider will be available to render services to a Member. If a Participating Provider no longer Participates with the Plan, upon the issuance or receipt of such a notice, the Plan will provide a written notice within thirty-one (31) days to all Members who are patients seen on a regular basis by the Participating Provider whose contract is terminating. Where a contract termination involves a PCP, all Members who are patients of the PCP shall be notified.

In the event a Participating Provider from whom You are receiving treatment discontinues participation or does not accept a Member as a patient, the Plan will assist You with selecting another Participating Provider to render such Covered Services. Please contact the Plan's Customer Service Department by calling the toll free number or accessing the website as provided on Your ID card and also the Schedule of Important Telephone Numbers in this COC.

Notwithstanding the above, if the continuation of care by a terminated Participating Provider is determined by the Plan to be Medically Necessary and in accordance with reasonable medical prudence, including circumstances such as disability, pregnancy, or life-threatening Illness, You may receive Authorization from the Plan to continue to receive Covered Services from that Provider for up to an additional ninety (90) days past the date of termination of the Provider's relationship with the Plan. During such period of continuation Coverage, You shall not be liable to the Provider for any amounts owed for medical care other than the applicable Copayment, and/or Coinsurance specified under the terms of the Agreement.

2.15 How to Contact The Plan

Throughout this Agreement, You will find that the Plan encourages You to contact the Plan for further information. Whenever You have a question or concern regarding Covered Services or any required procedure, please contact the Plan at the telephone number or website on the back of Your ID card.

Telephone numbers and addresses to request review of denied claims, register Complaints, place requests for prior Authorization, and submit claims are listed in the Schedule of Important Telephone Numbers And Addresses included in this COC.

2.16 Provider Hold Harmless

Participating Providers agree that in no event, including but not limited to nonpayment by the Plan or intermediary, insolvency of the Plan or intermediary, or breach of this Agreement, shall the Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Member or a person, other than the Plan or intermediary, acting on behalf of the Member for services provided pursuant to this Agreement. This Agreement shall not prohibit the Provider from collecting Coinsurance, or Copayments, as specifically provided in the COC, or fees for non-Covered Services delivered on a fee-for-service basis to You. The provider hold harmless provision shall not prohibit a Provider and You from agreeing to continue services solely at Your expense, as long as the Provider has clearly informed You that the Plan may not cover or continue to cover a specific service or services. Except as provided herein, this provision does not prohibit the Provider from pursuing any available

legal remedy, including but not limited to, collecting from any insurance carrier providing Coverage to a Member.

2.17 Plan Has Authority to Grant Coverage

Only Medically Necessary services are Covered under the Agreement. The fact that a Physician or other Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for an Injury, Illness or Substance Abuse, or Mental Illness does not mean that the procedure or treatment is Covered under the Agreement. The Plan shall have the right, subject to Your rights in this COC, to interpret the benefits of the COC, and other terms, conditions, limitations and exclusions set out in the Agreement in making factual determinations related to the Agreement, its benefits, and Members; and in construing any disputed or ambiguous terms. In accordance with all applicable law, the Plan reserves the right at any time, to change, amend, interpret, modify, withdraw or add benefits to, or terminate this Plan. The Employer Group will be given the proper written notice upon any termination or change in Coverage as required by applicable law. Any termination of the Agreement must be in accordance with the Termination of Coverage Section of this COC. The Plan may, in certain circumstances, cover services that would otherwise not be Covered. The fact that the Plan does so in any particular case shall not in any way be deemed to require it to do so in other similar cases.

2.18 Coverage for Services by Non-Participating Providers

If You wish to request that the Plan consider reimbursing You for Covered Services provided by Non-Participating Providers, You must obtain Prior Authorization from the Plan before receiving services even if you have received a referral from Your PCP.

2.19 How To File A Claim

A Non-Participating Provider may or may not complete and file the claim form for You. If not, You may obtain a Non-Participating claim form from the Plan's Customer Service Department within fifteen (15) days from the date the Plan receives notice of a claim from the Member. If a claim form is not provided to the Member within fifteen (15) days after the Plan receives notice of a claim from the Member, the Member making the claim shall be deemed to have complied with the requirements of the Plan as to proof of loss upon submitting written proof covering the occurrence, character, and extent of loss, within the time fixed for filing a claim. It is Your responsibility to provide any information that is necessary for the Plan to make a prompt and fair evaluation of Your claim. The Plan requests that You file the Non-Participating Provider claim within ninety (90) days from date of service. However, failure to file the claim within the ninety (90) day period shall not invalidate or reduce the claim, if it was not reasonably possible to provide notice or proof within the ninety (90) days. A claim will not be denied based upon the Member's failure to submit a claim within the ninety (90) day period unless the failure operates to prejudice the rights of the Plan. Claims submitted after the ninety (90) day period and in no event, except in the absence of legal capacity of the claimant, later than one (1) year and ninety (90) days from the date the services are received.

SECTION 3
ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

3.1 Subscriber Eligibility - To be eligible to be enrolled You must:

3.1.1 Live in the Service Area during the entire Year unless on temporary work assignment of four (4) months or less;

3.1.2 Be an Eligible Employee, Retiree or other Direct Bill member of the State of Kansas or other entities enrolled in the State's program, and eligible to participate equally in any alternate health benefits plan offered by the State of Kansas by virtue of his/her employment status;

3.1.3 Meet any eligibility criteria specified by the Employer Group and approved by the Plan, including, without limitation, the criteria set forth in the Group Master Contract; and

3.1.4 Complete and submit to the Plan such applications or forms that the Plan may reasonably request.

3.2 Dependent Eligibility - To be eligible to be enrolled under this Agreement as a Dependent, an individual must meet and continue to meet the Group's eligibility requirements:

3.2.1 Live in the Plan's Service Area at least six (6) months out of the year, except as permitted by Qualified Medical Child Support Orders, and

3.2.2 Be the lawful Spouse of the Subscriber; or

3.2.3 Be an unmarried dependent child of the Subscriber.

3.3 Change of Employer Group's Eligibility Rules

In order to be eligible for Coverage under this health benefit plan, individuals must meet specific Employer Group eligibility requirements. So long as this Agreement is in effect, any change in the Employer Group's eligibility requirements must be approved in advance by the Plan.

3.4 Medicare Eligibility

A member who is eligible to be Covered under Medicare (Title XVIII of the Social Security Act as amended) and for whom Medicare can be the primary payer of claims shall enroll in Medicare Part A and B Coverage on the later of the date he or she is first eligible for Medicare or the Effective Date of this Agreement. If Medicare could have paid, the plan will subtract what Medicare would have paid had the member enrolled when calculating claims payments due.

3.5 Persons Not Eligible to Enroll

3.5.1 A person who fails to meet the eligibility requirements specified in this Agreement shall not be eligible to enroll or continue enrollment with the Plan for Coverage under this Agreement.

3.5.2 A person whose Coverage under this Agreement was terminated due to a violation of a material provision of this Agreement shall not be eligible to enroll with the Plan for Coverage under this Agreement.

3.5.3 Late Enrollees are not eligible to enroll except during the next Group Enrollment Period, or during a Special Enrollment Period.

3.6 Enrollment

3.6.1 All individuals meeting the eligibility requirements of this section may enroll with the Plan for Coverage under this Agreement during the Group Enrollment Period or a Special Enrollment Period.

3.6.2 Any new employee or employee who transfers into the Plan's Service Area may enroll with the Plan for Coverage under this Agreement within thirty-one (31) days after becoming eligible. If the employee fails to submit an Employee Enrollment/Change Form for purposes of enrolling with the Plan for Coverage under this Agreement within thirty-one (31) days after becoming eligible, he or she is not eligible to enroll until the next Group Enrollment Period unless there is a special enrollment.

3.6.3 A special enrollee may enroll with the Plan for Coverage under this Agreement as provided below.

3.6.4 Eligible Employees or their Dependents who do not enroll during an initial eligibility period, or within thirty-one (31) days of first becoming eligible for Coverage under this Agreement are not eligible to enroll until the next open enrollment period, unless they are eligible to enroll as a special enrollee, as described below.

3.7 Special Enrollment

3.7.1 **Special Enrollment Due to Loss of Other Coverage**. Subject to the conditions set forth by the Group, an Eligible Employee and his or her Dependents may enroll in the Plan if the Eligible Employee waived initial Coverage under the Plan at the time Coverage was most recently made available because the Eligible Employee or Dependent had other Coverage at the time Coverage under the Plan was offered and the Eligible Employee or Dependent meets the requirements of the Group for a special enrollment and the Eligible Employee's or Dependent's other coverage:

3.7.1.1 Was COBRA continuation coverage that has since been exhausted; or,

3.7.1.2 If not COBRA continuation coverage, such other coverage terminated due to a loss of eligibility for such coverage or employer contributions toward the other coverage terminated. The term "loss of eligibility for such coverage" includes (1) a loss of coverage due to legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, (2) in the case of Coverage offered through an HMO, loss of Coverage because the Employee or Dependent no longer lives in the HMO's service area. This term does not include loss of coverage due to failure to timely pay required contributions or Premiums or loss of coverage for cause (i.e., fraud or intentional misrepresentation); or

3.7.1.3 A situation in which the Employee or Dependent incurs a claim that would meet or exceed a lifetime limit on all benefits offered under the other Coverage.

Required Length of Special Enrollment**.** An employee and his or her Dependents must request special enrollment in writing no later than thirty-one (31) days from the date that the other Coverage was lost, or in the case where the Employee or Dependent has exceeded a lifetime limit on all benefits offered under the other

Coverage, no later than thirty-one (31) days after a claim is first denied due to the operation of a lifetime limit on all benefits..

Effective Date of Coverage**.** The effective date of coverage will be determined by the Group.

3.7.2 Enrollment Due to New Dependent Eligibility. Subject to the conditions set forth by the Group, an Eligible Employee and his or her Dependents may enroll in the Plan if the Eligible Employee has acquired a Dependent through marriage, birth, adoption or placement for adoption.

Required Length of Special Enrollment**.** An Eligible Employee and his or her Dependents must request special enrollment in writing no later than thirty-one (31) days from the date of marriage, birth, adoption or placement for adoption.

Effective Date of Coverage. The effective date of coverage will be determined by the Group.

3.7.3 Notification of Change in Status. A Covered employee must notify the Plan of any changes in status or the status of any Dependent within thirty-one (31) days after the date of the qualifying event. This notification must be submitted on a written Employee Enrollment/Change Form to the Group. Events qualifying as a change in status include, but are not limited to, changes in address, employment, divorce, marriage, dependency status, Medicare eligibility or Coverage by another payer. The Plan should be notified within a reasonable time of the death of any Member.

3.8 Subscriber Effective Date

3.8.1 During Group Enrollment Period: An Eligible Employee and their Eligible Dependent(s), who enroll during a Group Enrollment Period shall be Covered under this Agreement as of the date stated in the Group Master Contract.

3.8.2 Newly Hired Employees: A newly hired Eligible Employee, and their Eligible Dependent(s), shall be Covered under this Agreement as of the date that he or she first becomes eligible for Coverage, according to the terms of the Group Master Contract, so long as the Group receives the employee's completed Employee Enrollment/Change Form within thirty-one (31) days of becoming eligible for Coverage.

3.8.3 Newly Eligible Employees: An Eligible Employee, and their eligible Dependent(s), who become eligible for Coverage under this Agreement during the contract year, shall be Covered as of the first (1st) day of the month following the date that he or she first becomes eligible so long as the Group receives the employee's completed Employee Enrollment/Change Form within thirty-one (31) days of becoming eligible for Coverage.

3.8.4 Special Enrollees: Special enrollees shall be Covered under this Agreement as provided in this Section.

3.9 Effective Date for Dependents

3.9.1 Eligible Dependents who are special enrollees shall be Covered under this Agreement as stipulated in the Special Enrollment Section provided that a child born to the Subscriber or Subscriber's Spouse is automatically Covered for the treatment of Injury or Illness, including medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care, for the first thirty-one (31) days from the date of birth. To the extent permitted by applicable state law, additional premium shall be paid for this Coverage. For Coverage to continue

beyond the first thirty-one (31) days, application to add the child as a Dependent must be received within thirty-one (31) days from the date of birth. Upon notification, if additional forms are required the Member will be provided all forms and instructions necessary to enroll the newly born child and an additional ten (10) days from the date the forms and instructions are provided in which to enroll the newly born child.

3.9.2 An adopted child is Covered from the date of birth if a petition for adoption is filed within thirty-one (31) days of the birth of such child or from the date of placement for the purpose of adoption if a petition for adoption is filed within thirty-one (31) days of placement of such child. Such Coverage shall continue until the legal adoption occurs or the date that the placement is disrupted prior to legal adoption and the child removed from placement. In this section, placement means in the physical custody by the adoptive parent.

3.9.3 Dependents eligible for Coverage as a result of a Qualified Medical Child Support Order (QMCSO) shall be Covered as of the date specified in the order. If no date is specified in the order, Coverage shall be effective as of the date the order is issued by the court. In addition, a Subscriber, a state agency, or an Alternate Recipient may enroll a Dependent child pursuant to the terms of a valid QMCSO. A child who is eligible for Coverage pursuant to a QMCSO may not enroll Dependents for Coverage under the Plan.

3.9.4 Dependent Coverage under the Plan is subject to payment of the required contribution by the Subscriber, if any contribution is required. In the case of a child who is eligible for Coverage pursuant to a QMCSO, payment of the required contribution is to be made for such child, by the custodial parent or legal guardian of such child, or by a state agency. The Plan will notify the Employer Group of the amount of the required total Premium payable to the Plan. Upon agreement by the Plan and the Employer Group, the parties may change the required Premium contribution of Subscribers.

3.10 Inpatient on the Member Effective Date

If You are Covered under an extension of benefits provision pursuant to state law or from a prior plan, services or supplies that are Covered, or required to be Covered, under an extension of benefits provision under the prior plan will be Covered under this Agreement subject to the Agreement's Coordination of Benefits Section.

SECTION 4
TERMINATION OF COVERAGE

4.1 Termination of Coverage For Members

Your Coverage shall terminate, on the date specified by the Group, if any one of the following events occurs:

4.1.1 You no longer meet the eligibility requirements set forth by the Group.

4.1.2 You fail to pay premiums. NOTE: In the event that the Plan has not received payment of premium at the end of the thirty-one (31) days notice period (and any grace period, if applicable), you will be retroactively terminated to the date Covered by Your last paid premium. You will be responsible for the value of services rendered during the thirty-one (31) days notice period (and any grace period, if applicable).

4.1.3 You fail to pay supplemental charges. A Member may have their Coverage terminated for nonpayment of copayment or coinsurance to the Provider under the following conditions: (1) the Provider has initiated collection efforts within sixty (60) days after the Plan is notified that copayment is due. (2) The enrollee has received written notice from the Plan stating the disenrollment will occur unless arrangements for payment of the copayment are made within ten (10) working days after receipt of the notice.

4.1.4 Knowingly misrepresenting or giving false information on any enrollment application form which is material to the Plan's acceptance of such application. The validity of the policy shall not be contested, except for non-payment of premiums, after the Plan has been in force for two years from the date of issue, and no initial statement made by a Member regarding insurability shall be used as a reason for disenrollment after the Plan has been in force for two years from the date of issue.

4.1.5 You participate in fraudulent or criminal behavior, including but not limited to:

4.1.5.1 Performing an act or practice that constitutes fraud or intentionally misrepresenting material facts including using Your identification card to obtain goods or services which are not prescribed or ordered for You or to which You are otherwise not legally entitled. In this instance, Coverage for the Subscriber and all Dependents will be terminated.

4.1.5.2 Allowing any other person to use Your identification card to obtain services. If a Dependent allows any other person to use his/her identification card to obtain services, the Coverage of the Dependent who allowed the misuse of the card will be terminated. If the Subscriber allows any other person to use his/her identification card to obtain services, the Coverage of the Subscriber and his/her Dependents will be terminated.

4.1.5.3 Threatening or perpetrating violent acts against the Plan, a Provider, or an employee of the Plan or a Provider. In this instance, Coverage

for the Subscriber and all Dependents will be terminated.

4.1.6 You and Your Physician fail to establish a satisfactory patient-Physician relationship and:

4.1.6.1 The Plan has, in good faith, provided You with the opportunity to select an alternative Physician;

4.1.6.2 You have repeatedly refused to follow the plan of treatment ordered by the Physician;

4.1.6.3 You have been notified by the Plan in writing at least thirty-one (31) days in advance that the patient-Physician relationship is unsatisfactory and specific changes are necessary in order to avoid termination; and

4.1.6.4 You have failed to make a good faith effort to make the specific changes outlined in the Plan's notice detailed above.

4.1.6.5 If a Dependent fails to establish a satisfactory patient-Physician relationship, only the Coverage of the Dependent shall be terminated. If the Subscriber fails to establish a satisfactory patient-Physician relationship, the Coverage of the Subscriber and his/her Dependents will be terminated.

4.2 Termination of Coverage without Notice. Your Coverage shall immediately terminate if any one of the following events occurs:

4.2.1 Termination or non-renewal of the Group Master Contract, by the Employer Group.

4.2.2 The Plan receives written notice from the Employer Group instructing the Plan to terminate Your Coverage.

4.3 Effect of Termination.

4.3.1 If Your Coverage under this Agreement is terminated under this Section, all rights to receive Covered Services shall cease as of the date of termination.

4.3.2 Identification cards are the property of the Plan and, upon request, shall be returned to Us within thirty-one (31) days of the termination of Your Coverage. Identification cards are for purposes of identification only and do not guarantee eligibility to receive Covered Services.

4.3.3 Your Coverage cannot be terminated on the basis of the status of Your health or the exercise of Your rights under the Plan's Grievance and Complaint procedures. The Plan may not terminate an Agreement solely for the purpose of effecting the disenrollment of an individual Member for either of these reasons.

4.3.4 If the Member receives Covered Services after the termination of Coverage, the Plan may recover the contracted charges for such Covered Services from You or the Provider, plus its cost to recover such charges, including attorneys' fees.

4.3.5 Under certain circumstances, Members may be eligible for continuation of Coverage benefits or to convert to another policy as described in the Continuation, Conversion, and Extension of Benefits Section.

4.4 Discontinuation of Coverage

If the Plan decides to discontinue offering Coverage under the COC, You will receive a written notice of discontinuation at least ninety (90) days before the date the Coverage will be discontinued. Your Employer Group will be offered the opportunity, on a guaranteed issue basis, to purchase for You any other Coverage offered by the Plan. If the Plan elects to discontinue offering all health insurance Coverage in the group market, You will receive a written notice of discontinuation at least one hundred and eighty (180) days before the date the Coverage will be discontinued.

4.5 Certificates of Creditable Coverage.

At the time Coverage terminates, You are entitled to receive a certificate verifying the type of Coverage, the date of any waiting periods, and the date any Creditable Coverage began and ended.

SECTION 5
COVERED SERVICES

The Plan covers only those services and supplies that are (1) deemed Medically Necessary, (2) provided by a Participating Provider (3) Authorized, if Authorization is required, (4) not expressly excluded in the list of Exclusions and Limitations section as set forth in this COC, and (5) incurred while the Member is eligible for Coverage under the Plan.

The following section, **Covered Services**, provides the services and supplies Covered under this Agreement. All Prior Authorizations and determinations referenced in the Covered Services Section are made by the Plan. If a service is not specifically listed and not otherwise excluded, please contact the Plan to confirm whether the service is a Covered Service.

Abortion Coverage -

A. Abortions and abortion related services will be covered in the following:

(1) Where the life of the mother would be endangered if the fetus were carried to term;

(2) Termination of a tubal pregnancy; or

(3) Prior to the eighth week of pregnancy, if the pregnancy is the result of an act of rape or incest.

B. Medical complications that have arisen from an abortion will be covered.

Allergy Services - Coverage is provided for allergy testing, diagnosis, treatment, allergy serum, and the administration of injections.

Ambulance (air and ground) - Coverage is provided for Emergency ambulance transportation, when transport by other means is not medically safe, by a licensed ambulance service to the nearest Hospital where Emergency services can be rendered.

Blood and Blood Products Processing - Coverage is provided for administration, storage, and processing of blood and blood products in connection with services Covered under this COC.

Breast Reconstruction - Coverage is provided for breast Reconstructive Surgery and prosthesis following a Medically Necessary mastectomy resulting from cancer. As required by the Women's Health and Cancer Rights Act (WHCRA), if You elect breast reconstruction after a Covered mastectomy, benefits will be provided for augmentation and reduction of the affected breast, augmentation or reduction on the opposite breast to restore symmetry, prosthesis, and treatment of physical complications at all stages of the mastectomy, including lymphedema. This also includes nipple reconstruction.

Chemotherapy - Coverage is provided for standard chemotherapy, including, but not limited to, dose-intensive chemotherapy for the treatment of breast cancer. Chemotherapy benefit is subject to the Plan's Experimental and Investigational exclusion.

Child Health Services - Coverage is provided for the periodic review of a Dependent child's physical and emotional status by a Physician or pursuant to a Physician's supervision. A review shall include a history, complete physical examination, development assessment, anticipatory guidance, appropriate immunizations and laboratory tests consistent with prevailing standards. Periodic reviews are Covered, at a minimum, from the date of birth through the age of twelve years at the following intervals: birth, two months, four months, six months, nine months, twelve months, eighteen months, two years, and yearly after age two.

Colorectal Cancer Screening - Coverage is provided for a colorectal cancer exam and related laboratory testing for any asymptomatic Member pursuant to the Plan's criteria, which are in accordance with the current American Cancer Society and U.S. Preventive Services Taskforce guidelines.

Dental Services - Coverage is provided for the removal of tumors and cysts of the jaws, lips, cheeks, tongue, roof and floor of the mouth, and removal of bony growths of the jaw, soft and hard palate. Also Covered are lacerations to the mouth, tongue and gums. There shall also be Coverage for the administration of general anesthesia and Hospital charges for dental care provided to the following Members when Authorized in advance by the Plan:

(1) A Dependent child age of five and under;

(2) A Member who is severely disabled; or

(3) A Member who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

The Coverage for the administration of general anesthesia and Hospital charges must be provided by a Participating provider regardless of whether the dental services are provided in a Hospital, surgical center or office.

Oral Surgery and Diseases of the Mouth - Coverage includes only Authorized oral surgical services limited to the reduction or manipulation of fractures and dislocation of jaw and of facial bones; intra-oral x-rays and pathology associated with a Covered oral surgery; excision of lesions of the mandible, mouth, lip, or tongue; incision of accessory sinuses, mouth, salivary glands, or ducts; reconstruction or repair of the mouth or lip necessary to correct anatomical functional impairment caused by congenital defect.

Coverage is provided for diseases of the mouth, unless the condition is due to dental disease or of dental origin. Please also see the Exclusions Section regarding oral surgery and dental services.

Dermatological Services - Coverage is provided for the necessary removal of a skin lesion that interferes with normal body functions or is suspected to be malignant.

Dialysis - Coverage is provided for hemodialysis and peritoneal services provided by Participating outpatient or inpatient facilities or at home. For home dialysis, equipment, supplies, and maintenance will be a Covered Service.

Diabetic Supplies - Coverage includes Plan approved glucose meters and self-management training used in connection with the treatment of diabetes, insulin pump and supplies. Please note, disposable insulin syringes, glucose strips, and lancets are Covered under the pharmacy benefit.

Durable Medical Equipment (DME) - Coverage is provided when determined to be necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body member.

The wide variety of DME and continuing development of patient care equipment makes it impractical to provide a complete listing of Covered or non-Covered equipment here. Therefore, the Plan may approve requests on a case by case basis. The Plan may rent or purchase DME. The Plan will Authorize use of DME for a limited period of time. Please note, upgrades to equipment are the responsibility of the Member.

Emergency Services - Coverage is provided for health services and supplies furnished or required to screen and stabilize an Emergency Medical Condition provided on an outpatient basis at either a Hospital or an Alternate Facility. You should notify Your Physician and the Plan within 48 hours of admission or the next business day or as soon as physically able.

Eye Glasses and Corrective Lenses - Not a Covered Service, except for the first pair of

eyeglasses or corrective lenses following surgery for cataracts, aphakia, or pseudophakia, limited to $150.

Family Planning - Coverage is provided for family planning counseling, treatment and follow-up, information on birth control, insertion and removal of intra-uterine devices and Norplant, and measurement for contraceptive diaphragms. Also covered, after appropriate counseling, medical services connected with elective surgical sterilization, including vasectomy, tubal ligation.

Genetic Counseling - Coverage is provided for genetic counseling and genetic studies only when required for diagnosis or treatment of genetic abnormalities where historical evidence suggests a potential for such abnormalities and the testing will alter the outcome of treatment.

Gynecological Examinations - Coverage is provided for well-woman examinations, including services, supplies and related tests by a Participating obstetrician, gynecologist or obstetrician/gynecologist, in accordance with the current American Cancer Society and the U.S. Preventive Services Taskforce Guidelines.

Hearing Screenings - Coverage is provided for a hearing screening to determine hearing loss.

Home Health Care Services - Coverage is provided when all of the following requirements are met:

(1) the service is ordered by a Participating Physician;

(2) services required are of a type which can only be performed by a licensed nurse, physical therapist, speech therapist, respiratory therapist, or occupational therapist;

(3) part-time intermittent services are required;

(4) a treatment plan has been established and periodically reviewed by the ordering Physician;

(5) the services are Authorized by the Plan; and

(6) the agency rendering services is licensed by the State of location.

Hospice - Coverage is provided for hospice care rendered by a Participating Provider for treatment of a terminally ill Member when ordered by a Participating Physician. Care through a hospice program includes supportive care involving the evaluation of the emotional, social and environmental circumstances related to or resulting from the Illness, and guidance and assistance during the Illness for the purpose of preparing the Member and the Member's family for a terminal Illness.

Immunizations - Coverage is provided for immunizations Covered for Dependent children pursuant to the Plan's criteria and appropriate state law. Adult immunizations are Covered as per guidelines of the Center for Disease Control and Prevention (CDC) and the U.S. Preventive Services Taskforce Guidelines.

Infertility - Coverage is provided for diagnostic studies and certain surgical procedures, which are related to diagnosing Infertility when listed in the Schedule of Benefits. Artificial insemination will be covered up to a maximum of three (3) billable attempts per benefit period subject to prior authorization by the Plan. No coverage shall be provided for donor fees, donor collection and/or storage of sperm or any other donor-related services.

Inpatient Hospital Care - Coverage includes semi-private accommodations and associated professional and ancillary services. Certain services rendered during a Member's Confinement may be subject to separate benefit restrictions and/or Copayments as described in the Schedule of Benefits. Please see the Exclusions Section regarding Private inpatient room.

Maternity Services - Members may self-refer to any Participating obstetrician or gynecologist for Covered Services. Maternity-related Covered Services are treated as any other Illness. Hospital Coverage for the mother and her newborn child includes forty-eight (48) hours of post-

natal maternity care for vaginal delivery and ninety-six (96) hours of post-natal maternity care for cesarean delivery. The Plan may authorize a shorter hospital stay if the attending provider, after consulting with the mother, approves discharging earlier than 48 hours (or 96 hours as applicable). The discharge shall be made in accordance with the most current version of the "Guidelines for Perinatal Care", or similar guidelines; and the Plan shall provide post-discharge care consisting of two visits by a registered professional nurse. The location and schedule of the post-discharge visits shall be determined by the attending physician who has approved the early discharge. Inpatient Hospital services may be subject to Member responsibility as defined in the Schedule of Benefits.

Benefits include the birth mother's delivery expenses of a Child adopted by a Member within ninety (90) days of such Child's birth. A Participating Provider must provide services, which shall be subject to the limitations and exclusions of this Agreement.

Newborn Care - The Covered Services for eligible newborn children shall consist of Coverage for Injury or Illness, Reconstructive Surgery for the treatment of medically diagnosed congenital defects or birth abnormalities. Coverage is provided for all eligible newborns to be tested or screened for phenylketonuria (PKU) and such other common metabolic or genetic diseases.

Coverage is also provided for newborn hearing screening examinations, any necessary re-screening, audiological assessment and any requisite follow-up.

Nutritional Counseling - Coverage is provided for one nutritional counseling session as recommended by a physician when provided by a Registered Dietician and authorized by the Plan.

Orthotic Devices - Coverage is provided for the initial purchase of Orthotic Appliances following the onset or initial diagnosis of the condition for which the device is required. These services must be Authorized in advance by the Plan and obtained from a Participating Provider. Coverage is provided for Orthotic Appliances, splints and braces, including necessary adjustments to shoes to accommodate braces. Shoe inserts will be Covered only if the Member has diabetes with demonstrated peripheral neuropathy or the insert is needed for a shoe that is part of a brace. Please also see Exclusions Section regarding Orthotic Appliances

Osteoporosis - Coverage is provided for services related to diagnosis, including central bone density test; medically necessary treatment and appropriate management of osteoporosis. In determining medical appropriateness, due consideration shall be given to peer-reviewed medical literature.

Outpatient Diagnostic Services - Coverage is provided for services and supplies for outpatient diagnostic services provided under the direction of a Participating Provider at a Participating Hospital or Participating Alternate Facility. Coverage for testing pregnant women and children for lead poisoning shall be covered as any other outpatient diagnostic service. Also covered is human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing for A, B, and DR antigens.

Outpatient Surgery - Coverage is provided for services and supplies for outpatient surgery provided under the direction of a Participating Provider at a Participating Hospital or Participating Alternate Facility.

PKU or any other Amino and Organic Acid Inherited Disease Formula/Food - Coverage is provided for formula used for PKU or any other amino and organic acid inherited disease that is recommended by a Participating Provider as determined by the Plan to be Medically Necessary.

Physician Services - Coverage is provided for Participating Physician Services, including but not limited to, office visits, Hospital visits, consultations, and interpretation of tests.

Preventive Services - Coverage is provided for wellness benefits including:

1. Immunizations (except those required for travel or employment) as recommended by the

American Academy of Pediatrics or other nationally recognized health care agency. Covered Services for routine and necessary immunizations for Dependent children from birth up to 72 months shall be provided at 100% of the allowable charge and will not be subject to any Copayment requirements. Adult immunizations are Covered as per guidelines of the Center for Disease Control and Prevention (CDC) and the U.S. Preventive Services Taskforce Guidelines. Any office visit charges incurred, in conjunction with these immunizations will be payable as described in the Schedule of Benefits;

2. Well child care;
3. Flu shots;
4. Cholesterol screening, HDL cholesterol, lipid panel, triglycerides;
5. Complete Blood Count (CBC);
6. Comprehensive metabolic panel;
7. Coronary artery disease risk screening, such as routine laboratory tests, physical examination, and routine EKG;
8. Blood pressure screening;
9. Colorectal examinations;
10. Fecal occult blood screening;
11. Urinalysis (UA);
12. Creatinine;
13. Annual gynecological examination and Pap Smear, including STD testing when provided at the time of a well woman exam; Members may self-refer to any Participating obstetrician or gynecologist for Covered Services;
14. One (1) mammogram per Calendar Year or more frequently if ordered by a Physician. You may self-refer to a participating mammography center for one annual routine mammogram; and
15. Both a prostate-specific antigen blood test and a digital rectal exam for men 40 years of age or older who are symptomatic or in a high-risk category and for all men 50 years of age or older.

Prosthetic Devices - Coverage is provided for the initial purchase of Prosthetic Devices following the onset or initial diagnosis of the condition for which the device is required. For Prosthetic Device placements requiring a temporary and then a permanent placement only one (1) temporary device will be Covered. These services must be Authorized in advance by the Plan and obtained from a Participating Provider. Coverage is provided for Prosthetic Devices, including but not limited to, purchase of artificial limbs, breasts, and eyes, which meet the minimum requirements or specifications which are Medically Necessary for treatment, limited to the basic functional device which will restore the lost body function or part. Coverage is provided for external Prosthetic Devices that are used in lieu of surgery for breast reconstruction due to a mastectomy.

Coverage will be provided for one permanent Prosthetic Device per member, per extremity, per lifetime unless the Prosthetic Device becomes non-functional and non-repairable due to normal usage and change in condition or routine wear and tear. Prosthetics will be replaced for documented growth in a Dependent child requiring replacement. Polishing and resurfacing of eye prosthetics are Covered. Stump stockings and harnesses are covered when they are essential to the effective use of an artificial limb.

Coverage for prosthetic devices, with the exception of internal prosthetic devices, will be subject

to the benefit limit as expressed in the Schedule of Benefits. Please also see the Exclusions Section regarding Prosthetic Devices.

Radiation Therapy – Coverage is provided for care and services for radium and radioactive isotope therapy.

Reconstructive Surgery - Services are limited to the surgical correction of congenital birth defects or the effects of disease or Injury, which cause anatomical functional impairment, when such surgery is reasonably expected to correct the functional impairment.

Coverage for reconstructive surgery for a congenital birth defect shall be Covered only for a newly born Member, also please see the Exclusions Section regarding Cosmetic Services and Surgery.

Rehabilitation Services – Coverage is provided for short-term therapy services that are expected to result in significant functional improvement of the Member's condition, limited to physical therapy, occupational therapy, spinal manipulation, pulmonary therapy, and speech therapy for loss or impairment of speech or hearing. The phrase "loss or impairment of speech or hearing" shall include those communicative disorders generally treated by a speech pathologist, audiologist or speech/language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association (ASHA), or both and which fall within the scope of his/her license or certification. Outpatient therapy services must be performed by a Participating Provider including, a Participating free standing rehabilitation facility and Authorized in advance by the Plan.

Outpatient rehabilitation services must be provided under the direction of a Participating Provider and Authorized in advance by the Plan.

Sleep Studies – Coverage is provided for sleep studies performed.

Skilled Nursing Facility - Coverage is provided for Confinement (on a Semi-private Accommodations basis) and medical services and supplies provided under the direction of a Participating Provider in a Participating Skilled Nursing Facility. Services rendered in a Participating Skilled Nursing Facility are Covered only for the care and treatment of an Injury or Illness which cannot be safely provided in an outpatient setting, as determined by the Plan.

Coverage in a Skilled Nursing Facility may be subject to a Calendar Year limitation as specified in the Schedule of Benefits. Certain ancillary services rendered during a Member's Confinement are subject to separate benefit restrictions and/or Member responsibilities as described elsewhere in this COC or in the Schedule of Benefits.

Therapeutic Injections and IV Infusions - Coverage is provided for Injectable and Self-Injectable medications when FDA-approved, medically appropriate subject to the Plan's formulary list and substitute Coverage by therapeutically interchangeable drugs, according to clinical guidelines used by the Plan. Please note that certain Self-Injectable medications may be Covered by the pharmacy benefit.

Visions Services - Coverage is provided for one routine eye examination, including refraction each benefit year as described in the Schedule of Benefits. Please also see the Exclusions Section regarding vision services that are specifically denied under the Plan.

5.1 Emergency Benefits

In the event You experience an Emergency Medical Condition, You should obtain medical attention from the nearest Hospital or through 911 emergency services (where available). Screening and stabilization services provided in a Hospital emergency room for an Emergency Medical Condition may be received from either Participating or Non-Participating Providers and are not required to be preauthorized.

You should contact Us within 48 hours of the onset of an Emergency Medical Condition

or as soon as is reasonably possible under the circumstances. The determination of Covered Services for services rendered in an emergency facility is based on the prudent layperson standard, along with those relevant symptoms and circumstances that preceded the provision of care. Services rendered by Non-Participating Providers or in Non-Participating facilities are not a Covered Service if You remain in a Non-Participating facility after We have made the appropriate arrangements for transfer to a Participating facility. If Medically Necessary follow-up care related to the initial Emergency Medical Condition service is required, you should contact and coordinate with Your PCP.

5.2 Urgent Care Benefits

Urgent Care is Medically Necessary care for an unexpected illness or injury that does not qualify as an Emergency Medical Condition but requires prompt medical attention. Your Provider can help You determine whether or not You need to receive care at an Urgent Care Center.

If possible, please contact Your PCP in the event Urgent Care services are/were rendered. Your PCP is available to provide guidance and direction in situations that may require Urgent Care. However, failure to notify Your PCP will not result in denial of Coverage. If Medically Necessary follow-up care related to the initial Urgent Care service is required, you should contact and coordinate with Your PCP.

5.3 Mental Health, Alcohol and Drug Abuse Services Benefits

The Plan provides Mental Health, Alcohol and Drug Abuse Coverage as required by applicable state law. The Plan contracts with an outside vendor to coordinate and determine Medical Necessity of the diagnosis and treatment of all Mental Illnesses, psychiatric conditions, and Substance Abuse (Mental Health and Substance Abuse). If You have any questions about Your Mental Health and Substance Abuse Coverage, the appropriate way to access Coverage, or to prior authorize care for Mental Health and Substance Abuse, you must contact the contracted vendor. The vendor's name and telephone number are listed on the back of Your ID card, in the Directory of Health Care Providers, and on the Schedule of Important Telephone Numbers and Addresses.

If services are provided for a condition that is included in the definition of Biologically Based Mental Illness, services will be covered same as any other medical condition.

5.4 Transplant Services

Services related to Medically Necessary organ transplants are Covered when approved by the Plan, performed at a Coventry Transplant Network participating facility and the recipient is a Member.

Donor screening tests are Covered and are subject to a lifetime benefit maximum of $10,000 when performed at a Coventry Transplant Network participating facility.

If not Covered by any other source, the cost of any care, including complications up to 90-days, arising from an organ donation by a non-Member when the recipient is a Member will be Covered for the duration of the Agreement of the Member when approved by the Plan.

Coverage shall include the treatment of breast cancer by autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in autologous bone marrow transplants or stem cell transplants.

The cost of any care, including complications, arising from an organ donation by a Member when the recipient is not a Member is Excluded.

5.5 Travel for Transplant Services

If the Member resides more than one hundred-fifty (150) miles from the transplant facility, reimbursement for travel will be Covered. Travel expenses may include the lodging for one family member or responsible adult. Lifetime limitation for travel and lodging are determined by the Plan.

SECTION 6
EXCLUSIONS AND LIMITATIONS

The following items are excluded from Coverage:

1) Any service or supply that is not provided by Participating Providers in accordance with the Plan's utilization management policies and procedures, except that Emergency Services shall be Covered in accordance with the terms and conditions set forth in this Agreement;
2) Any service or supply that is not Medically Necessary;
3) Any service or supply that is not a Covered service or that is directly or indirectly a result of receiving a non-Covered Service;
4) Any service or supply for which You have no financial liability or that was provided at no charge; those services for which the Member has no legal obligation to pay or for which a charge would not ordinarily be made in the absence of Coverage under the Agreement;
5) Non-Emergency services provided outside the Service Area, including elective care, obstetrical services after 37 weeks of pregnancy, follow-up care of an Illness or Injury, or care required as a result of circumstances that could have been reasonably foreseen by You before leaving the Service Area;
6) Procedures and treatments that the Plan determines and defines to be Experimental or Investigational;
7) Court-ordered services or services that are a condition of probation or parole;
8) Those services otherwise Covered under the Agreement related to a specific condition when a Member has refused to comply with, or has terminated the scheduled service or treatment against the advice of a Participating Provider or the Mental Health/Substance Abuse Designee;
9) Those services otherwise Covered under the Agreement, but rendered after the date Coverage under the Agreement terminates, including services for medical conditions arising prior to the date individual Coverage under the Agreement terminates; and
10) Those services rendered outside the scope of a Participating or Non-Participating Provider's license, rendered by a Provider with the same legal residence as a Member, or rendered by a person who is a member of a Member's family, including Spouse, brother, sister, parent, step-parent, child or step-child.

Specifically excluded services include, but are not limited to, the following:

1) Acupuncture - Those acupuncture services and associated expenses that include, but are not limited to, the treatment of certain painful conditions or for anesthesia purposes are not Covered;
2) Allergy Services - Those non-Physician allergy services or associated expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system cleaning;
3) Alternative Therapies - Alternative therapies including, but not limited to, aquatic, recreational, wilderness, educational, music or sleep therapies and any related diagnostic testing;
4) Ambulance Service - Non-Emergency and non-medically appropriate ambulance services are excluded regardless of who requested the services, including Ambulance transport due to the absence of other transportation for the Member;

5) Augmentative Communication Devices – Devices including but not limited to, those used to assist hearing impaired, or physically or developmentally disabled Members;

6) Autopsy - Those services and associated expenses related to the performance of autopsies to the extent that payment for such services is, by law, Covered by any governmental agency as a primary plan;

7) Behavior modification;

8) Biofeedback;

9) Blood and Blood Products – The cost of whole blood and blood products replacement to a blood bank;

10) Blood Storage - Those services and associated expenses related to personal blood storage, unless associated with a scheduled surgery. Additionally, fetal cord blood harvesting and storage is not a Covered service;

11) Braces and supports needed for athletic participation or employment;

12) Charges resulting from Your failure to appropriately cancel a scheduled appointment;

13) Cochlear Implants and related services;

14) Cosmetic Services and Surgery and any associated expenses;

15) Counseling - Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy are not Covered Services;

16) Custodial Care, Maintenance, domiciliary care, private duty nursing, respite care or rest care. This includes care that assists Members in the Activities of Daily Living like walking, getting in and out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets and supervision of medication that is usually self-administered regardless of who orders the services;

17) Dental Services - Those dental services provided by a Doctor of Dental Surgery, D.D.S., a Doctor of Medical Dentistry D.M.D. or a Physician licensed to perform dental-related oral surgical procedures, including services for overbite or underbite, services related to surgery for cutting through the lower or upper jaw bone, and services for the surgical treatment of temporomandibular joint disorder (TMJ), whether the services are considered to be medical or dental in nature except as provided in the "Covered Services" Section of this COC. Dental x-rays, supplies and appliances (including occlusal splints and orthodontia). The diagnosis and treatment for TMJ and craniomandibular joint disease is not Covered. Removal of dentiginous cysts, mandibular tori and odontoid cysts are excluded as they are dental in origin. Also excluded from Coverage are dental services when such services are directly related to an accidental injury. This includes, but is not limited to, treatment of natural teeth and the purchase, repair or replacement of dental prostheses needed as a direct result of an accidental injury;

18) Dental Surgery and Implants - Upper and lower jaw bone surgery and dental implants (including that related to the temporomandibular and craniomandibular joint). Dental implants are excluded. Removal of teeth as a complication of radionecrosis is not a Covered Service;

19) Durable Medical Equipment (DME) - Electronically controlled cooling compression therapy devices (such as polar ice packs, Ice Man Cool Therapy, or Cryo-cuff); home traction units; preventive or routine maintenance due to normal wear and tear or negligence of items owned by the Member; replacement for changes due to obesity;

personal comfort items, including breast pumps, air conditioners, humidifiers and dehumidifiers, even though prescribed by a Physician, unless defined as Covered Services;

20) Educational Services - Those educational services for remedial education including, but not limited to, evaluation or treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, mental retardation, developmental and learning disorders and behavioral training;

21) Equipment or services for use in altering air quality or temperature;

22) Educational testing or psychological testing, unless part of a treatment program for Covered Services;

23) Elective or Voluntary Enhancement - Elective or voluntary enhancement procedures, services, and medications (growth hormone and testosterone), including, but not limited to: weight loss, hair growth, sexual performance, athletic performance, Cosmetic purposes, anti-aging, mental performance, salabrasion, chemosurgery, laser surgery or other skin abrasion procedures associated with the removal of scars, tattoos, or actinic changes. In addition, service performed for the treatment of acne scarring, even when the medical or surgical treatment has been provided by the Plan;

24) Eligible Expenses - Any otherwise Eligible Expenses that exceed the maximum allowance or benefit limit;

25) Enteral Feeding Food Supplement - The cost of outpatient enteral tube feedings or formula and supplies except when used for PKU or any other amino and organic acid inherited disease is not Covered, except as defined as a Covered Service;

26) Examinations - Those physical, psychiatric or psychological examinations or testing, vaccinations, immunizations or treatments when such services are for purposes of obtaining, maintaining or otherwise relating to career, camp, sports, travel, employment, insurance, marriage or adoption. Also excluded are routine immunizations for services relating to judicial or administrative proceedings or orders which are conducted for purposes of medical research or to obtain or maintain a license of any type;

27) Exercise equipment, hot tubs and pools;

28) Eye Glasses and Contact Lenses - Those charges incurred in connection with the provision or fitting of eye glasses or contact lenses, except as specifically provided in the Covered Services Section;

29) Food or food supplements;

30) Foot Care – Foot care in connection with corns, calluses, flat feet, fallen arches or chronic foot strain. Medical or surgical treatment of onychomycosis (nail fungus) is also excluded, except as specifically provided for a diabetic Member;

31) Growth Hormone – Coverage is provided for growth hormone therapy only through the pharmacy benefit program of the Group.

32) Hair analysis, wigs and hair transplants - Those services related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also excluded are hairstyling, hairpieces and hair prostheses, including those ordered by a Participating Provider;

33) Home services to help meet personal, family, or domestic needs; Health and Athletic Club Membership - Any costs of enrollment in a health, athletic or similar club;

35) Hearing Services and Supplies - Those services and associated expenses for hearing aids, cochlear implants, digital and programmable hearing devices, the examination for

prescribing and fitting hearing aids, hearing therapy and any related diagnostic hearing tests;

36) Household Equipment and Fixtures - Purchase or rental of household equipment such as, but not limited to, fitness equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, water purifiers, hypo-allergenic pillows, power assist chairs, mattresses or waterbeds and electronic communication devices;

37) Hypnotherapy and Hypnosis;

38) Immunizations for travel, employment, or hobbies (personal pilots license, etc.) unless otherwise Covered under the Covered Services Section;

39) Infertility Treatment Services - Those non-diagnostic services and associated expenses for the promotion of conception including, but not limited to, artificial insemination, intracytoplasmic sperm injection (ICSI), in vitro or in vivo fertilization, gamete intrafallopian transfer (GIFT) procedures, zygote intrafallopian transfer (ZIFT) procedures, embryo transport, reversal of voluntary sterilization, surrogate parenting, selective reduction, cryo preservation, travel costs, donor eggs or semen and related costs including collection, preparation and storage, non-Medically Necessary amniocentesis, other forms of assisted reproductive technology and any Infertility treatment deemed Experimental or Investigational. Additionally, pharmaceutical agents used for the purpose of treating Infertility are not Covered;

40) No legal obligation to pay - Services are excluded for Injuries and Illnesses for which the Plan has no legal obligation to pay (e.g., free clinics, free government programs, court-ordered care, expenses for which a voluntary contribution is requested) or for that portion of any charge which would not be made but for the availability of benefits from the Plan, or for work-related injuries and Illness. Health services and supplies furnished under or as part of a study, grant, or research program;

41) Maintenance Therapy – Once the maximum therapeutic benefit has been achieved for a given condition, ongoing Maintenance Therapy is not considered Medically Necessary;

42) Male Gynecomastia – Those services and associated expenses for treatment of male gynecomastia.

43) Massage Therapy – Those services and associated expenses related to massage therapy;

44) Medical Complications arising directly or indirectly from a non-Covered Service;

45) Military Health Services - Those services for treatment of military service-related disabilities when the Member is legally entitled to other Coverage and for which facilities are reasonably available to the Member; or those services for any otherwise Eligible Employee or Dependent who is on active military duty except as required by the Uniformed Services Employment and Reemployment Rights Act; or services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;

46) Miscellaneous Service Charges - Telephone consultations, charges for failure to keep a scheduled appointment (unless the scheduled appointment was for a Mental Health service), or any late payment charge;

47) Non-Prescription Drugs and Medications - Over-the-counter (OTC) drugs and medications incidental to outpatient care and Urgent Care Services are excluded unless specifically stated as Covered in the Covered Services Section of this COC;

48) Nutritional-based Therapy - Nutritional-based therapies except for treatment of PKU and for nutritional deficiencies due to short bowel syndrome and human

immunodeficiency virus (HIV). Oral supplements and/or enteral feedings, either by mouth or by tube, are also excluded;

49) Newborn home delivery and also the cost of child birth classes;

50) Obesity Services - Those services and associated expenses for procedures intended primarily for the treatment of obesity and morbid obesity including, but not limited to, gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, wiring of the jaw, removal of excess skin, including pannus, and services of a similar nature. Services and associated expenses for weight loss programs, nutritional supplements, dietary counseling, appetite suppressants, and supplies of a similar nature;

51) Occupational Injury - Those services and associated expenses related to the treatment of an Occupational Injury or Illness for which the Member is eligible to receive treatment under any Workers' Compensation or occupational disease laws or benefit plans;

52) Oral Surgery Supplies - required as part of an orthodontic treatment program, required for correction of an occlusal defect, encompassing orthognathic or prognathic surgical procedures, or removal of symptomatic bony impacted teeth;

53) Orthodontia and related services;

54) Orthotic Appliances, Repairs or Replacement - Those repairs or replacement costs for any otherwise Covered appliance, including replacement for changes due to obesity; routine maintenance due to normal wear and tear or negligence of items owned by the Member; foot or shoe inserts, arch supports, special orthopedic shoes, heel lifts, heel or sole wedges, heel pads, or insoles whether custom-made or prefabricated, also excluded are cranial (head) remodeling band or any such service or supply for the treatment of positional non-synostotic plagiocephaly; and other protective head gear;

55) Over-the-counter supplies such as ACE wraps, elastic supports, finger splints, Orthotics, and braces; also OTC products not requiring a prescription to be dispensed (e.g., aspirin, antacids, cervical collars and pillows, lumbar-sacral supports, back braces, ankle supports, positioning wedges/pillows, herbal products, oxygen, medicated soaps, food supplements, and bandages) are excluded unless specifically stated as Covered in the Covered Services Section of this COC;

56) Personal comfort and convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies;

57) Private Duty Nursing - Private duty nursing services, nursing care on a full-time basis in Your home, or home health aides;

58) Prosthetic Devices Repairs or Replacement - Those repairs or replacement costs for any otherwise Covered device, including replacement for changes due to obesity; routine maintenance due to normal wear and tear or negligence of items owned by the Member;

59) Private inpatient room, unless Medically Necessary or if a Semi-private room is unavailable;

60) Reduction or Augmentation Mammoplasty - Reduction or augmentation mammoplasty is excluded unless associated with Breast Reconstruction Surgery following a Medically Necessary mastectomy incurred secondary to active disease;

61) Reversal of Sterilization Services - Those services and associated expenses related to reversal of voluntary sterilization;

62) Sex Transformation Services - Services and associated expenses for sex transformation operations regardless of any diagnosis of gender role disorientation or psychosexual orientation, including any treatment or studies related to sex transformation. Also excluded is hormonal support for sex transformation;

63) Sexual Dysfunction - Any device, implant or self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy;

64) Sleep Studies – Sleep studies provided within the home;

65) Smoking Cessation – Those services and supplies for smoking cessation programs and treatment of nicotine addiction;

66) Speech therapy or voice training when prescribed for stuttering or hoarseness;

67) Sports Related Services - Those services or devices used specifically as safety items or to affect performance primarily in sports-related activities, and all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation including braces and Orthotics;

68) Surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to the conception and pregnancy of a Member acting as a surrogate mother;

69) Third Party Liability - Services for which a third party has liability;

70) Transplant Organ Removal - Those services and associated expenses for removal of an organ for the purposes of transplantation from a donor who is not a Member unless the recipient is a Member and the donor's medical Coverage excludes reimbursement for organ harvesting;

71) Transplant services, screening tests, and any related conditions or complications related to organ donation when a Member is donating organ or tissue to a non-Member;

72) Transplant Services and associated expenses involving temporary or permanent mechanical or animal organs;

73) Travel Expenses - Travel or transportation expenses, even though prescribed by a Participating Provider, except as specified in the Covered Services Section;

74) Treatment for disorders relating to delays in learning, motor skills and communication, including any therapy for developmental delay;

75) Vision Aids, Associated Services - Those services and associated expenses for orthoptics or vision training, field charting, eye exercises, radial keratotomy, LASIK and other refractive eye surgery, low vision aids and services or other refractive surgery;

76) Vocational therapy;

77) Health services resulting from war or an act of war when the Member is outside of the continental United States;

78) Work hardening programs; and

79) Workers Compensation health services - Payment for services or supplies for an Illness or Injury eligible for, or Covered by, any Federal, State or local Government Workers' Compensation Act, occupational disease law or other legislation of similar program.

SECTION 7
COORDINATION OF BENEFITS

7.1 Coordination With Other Plans

This coordination of benefits (COB) provision applies when a Member has health care Coverage under more than one plan. "Plan" is defined below. The order of benefit determination rules described herein determine which plan will pay as the Primary Plan. The Primary Plan is the plan that pays first pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payments from all plans do not exceed 100% of the Plan's total Allowable Expense.

7.2 COB Definitions

A "Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated Coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

"Plan" includes: group insurance, closed panel or other forms of group or group-type Coverage (whether insured or uninsured); Hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law and subject to the rules on COB with Medicare set forth below.

"Plan" does not include: individual or family insurance; closed panel or other individual Coverage (except for group-type Coverage); amounts of Hospital indemnity insurance of $200 or less per day; school accident type Coverage, benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and Coverage under other governmental Plans, unless permitted by law.

Each contract for Coverage under this Section is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

The order of benefit determination rules determine whether the Plan is a "Primary" Plan or "Secondary" Plan when compared to another plan covering You or Your Covered Dependent. When the Plan is Primary, the Plan's benefits are determined before those of any other plan and without considering any other plan's benefits. When the Plan is Secondary, the Plan's benefits are determined after those of another plan and may be reduced because of the Primary Plan's payments.

"Allowable Expense" means a health care service or expense that is Covered, at least in part by any of the plan's covering You or Your Covered Dependent. When a plan provides benefits in the form of service (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not Covered by any of the plans is not an Allowable Expense. The following are examples of expenses or services that are not the Plan's Allowable Expenses:

1. If a Member is Confined in a private Hospital room, the difference between the cost of a Semi-private room in the Hospital and the private room, (unless the Member's stay in a private Hospital room is otherwise a Covered benefit).

2. Dental care, vision care, prescription drugs and hearing aids.

3. If a Member is Covered by two (2) or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees.

4. The amount a benefit is reduced by the Primary Plan because a Member does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

5. If a Member is Covered by one (1) Plan, which is secondary and calculates its benefits or services on the basis of usual and customary fees, and another Plan, which is primary and provides its benefits or services on the basis of negotiated fees, the lower of the two (2) plans' Allowable shall be the Allowable Expense for all Plans.

"Claim Determination Period" means a Calendar Year. However, it does not include any part of a year during which a Member has no Coverage under the Plan or before the date this COB provision or a similar provision takes effect.

"Closed Panel Plan" is a plan that provides health benefits to Covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of Emergency or referral by a panel member.

"Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one-half of the Calendar Year without regard to any temporary visitation.

"Joint Custody" If the specific terms of a court decree state that the parents shall share joint custody without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Section 7.3.

7.3 Order of Benefit Determination Rules

When two (2) or more plans pay benefits, the rules for determining the order of payment are as follows:

1. The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

2. A Plan that does not contain a COB provision that is consistent with this provision is always Primary. There is one exception: Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary Coverage shall be excess to any other

parts of the Plan provided by the contract holder. Examples of these types of situations are major medical Coverage's that are superimposed over base Plan Hospital and surgical benefits, and insurance type Coverage's that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

3. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is Secondary to that other plan.

4. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.

    a) Non-Dependent or Dependent. The plan that covers the Member other than as a Dependent, for example as an employee, Member, Subscriber or Retiree is Primary and the plan that covers the Member as a Dependent is Secondary. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the plan covering the Member as a Dependent; and Primary to the plan covering the Member as other than a Dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the Member as an employee, Member, Subscriber or Retiree is Secondary and the other plan is Primary.

    b) Child Covered Under More Than One (1) Plan. The order of benefits when a child is Covered by more than one (1) plan is:

        i. The Primary Plan is the plan of the parent whose birthday is earlier in the year if:

            (a) The parents are married;

            (b) The parents are not separated (whether or not they ever have been married); or

            (c) A court decree awards joint custody without specifying that one (1) party has the responsibility to provide health care Coverage.

        ii. If both parents have the same birthday, the plan that Covered either of the parents longer is Primary.

        iii. If the specific terms of a court decree state that one (1) of the parents is responsible for the child's health care expenses or health care Coverage, and the plan of that parent has actual knowledge of those terms, that plan is Primary. This rule applies to Claim Determination Periods or plan years commencing after the plan is given notice of the court decree.

        iv. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

            (a) The plan of the Custodial Parent;

            (b) The plan of the Spouse of the Custodial Parent;

            (c) The plan of the non-custodial parent; and then

(d) The plan of the Spouse of the non-custodial parent.

c) Active or inactive employee. The plan that covers a Member as an employee who is neither laid off nor retired, is Primary. The same would hold true if a Member is a Dependent of a person Covered as a Retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

d) Continuation Coverage. If a Member whose Coverage is provided under a right of continuation provided by federal or state law also is Covered under another plan, the plan covering the Member as an employee, Member, Subscriber or Retiree (or as that Member's Dependent) is Primary, and the continuation Coverage is Secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

e) Longer or shorter length of Coverage. The plan that Covered the Member as an employee, Member, Subscriber or Retiree longer is Primary.

f) If the preceding rules do not determine the Primary Plan, the Allowable Expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, the Plan will not pay more than the Plan would have paid had the Plan been Primary.

7.4 Effect On The Benefits of the Plan

When the Plan is Secondary, the Plan may reduce the Plan's benefits so that the total benefits paid or provided by all plans during a Claim Determination Period are not more than 100% of total Allowable Expenses. The difference between the benefit payments that the plan would have paid had the Plan been the Primary Plan, and the benefit payments that the Plan actually paid or provided shall be recorded as a benefit reserve for You or Your Covered Dependent and used by the Plan to pay any Allowable Expenses, not otherwise paid during the Claim Determination Period. As each claim is submitted, the Plan will:

1. Determine the Plan's obligation to pay or provide benefits under its contract;

2. Determine whether a benefit reserve has been recorded for You or Your Covered Dependent; and

3. Determine whether there are any unpaid Allowable Expenses during that Claim Determination Period.

If there is a benefit reserve, the Secondary Plan will use the Member's benefit reserve to pay up to 100% of the Plan's total Allowable Expenses incurred during the Claim Determination Period. At the end of the Claims Determination Period, the benefit reserve returns to zero. A new benefit reserve must be created for each new Claim Determination Period.

If a Member is enrolled in two (2) or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by

one (1) Closed Panel Plan, COB shall not apply between that plan and other Closed Panel Plans.

7.5 Coordination of Benefits with Medicare

Active Employees and Spouses Age 65 and Older

a) If an employee is eligible for Medicare and works for an Employer Group with fewer than twenty (20) employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding Calendar Year, then Medicare will be the primary payer. Medicare will pay its benefits first. The Plan will pay benefits on a secondary basis.

b) If an employee works for an Employer Group with more than twenty (20) employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding the Calendar Year, the Plan will be primary. However, an employee may decline Coverage under the Plan and elect Medicare as primary. In this instance, the Plan, by law, cannot pay benefits secondary to Medicare for Medicare -Covered services.

You will continue to be Covered by the Plan as primary unless You (a) notify the Plan, in writing, that You do not want benefits under the Plan or (b) otherwise cease to be eligible for benefits under the Plan, or (c) if we determine through some other means that we are not the primary carrier.

Disability

a) If You are under age 65 and eligible for Medicare due to disability, and actively work for a Employer Group with fewer than one-hundred (100) employees, then Medicare is the primary payer. The Plan will pay benefits on a secondary basis.

b) If You are age 65 or older and actively work for an Employer Group with at least one-hundred (100) employees and You become entitled to benefits under Medicare due to disability (other than ESRD as discussed below) the Plan will be primary for You and Your eligible Dependents and Medicare will pay benefits on a secondary basis.

End Stage Renal Disease (ESRD)

a) If You are entitled to Medicare due to End Stage Renal Disease (ESRD), the Plan will be primary for the first thirty (30) months. If the Plan is currently paying benefits as secondary, the Plan will remain secondary upon Your entitlement to Medicare due to ESRD.

Coordination of Benefits for Retirees

a) If You are retired and You or one of Your Dependents is Covered by Medicare Part A and/or Part B (or would have been Covered if complete and timely application had been made), benefits otherwise payable for treatment or services described in this Agreement will be paid after:

(i) Amounts payable are paid for treatment or services by Medicare Parts A and/or Part B;

(ii) Amounts that would have been payable (paid) for treatment or service by Medicare Parts A and/or Part B, if You or Your Dependents had been Covered by Medicare; or

(iii) Amounts paid under all other plans in which You participate.

7.6 Right to Receive and Release Needed Information

By accepting Coverage under this Agreement You agree to:

1. Provide the Plan with information about other Coverage and promptly notify the Plan of any Coverage changes;
2. Give the Plan the right to obtain information as needed from others to coordinate benefits;

7.7 Facility of Payment

A payment made under another plan may include an amount that should have been paid under the Agreement. If it does, the Plan may pay the amount to the organization that made the payment. The amount will then be treated as though it was a benefit paid under the Agreement. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

7.8 Right of Recovery

If the amount of the payment made by the Plan, including the reasonable cash value of any benefits provided in the form of services, is more than it should have paid under the terms of the Agreement, the Plan may recover the excess payments from one (1) or more of:

1. The persons it has paid;
2. For whom it has paid;
3. Insurance companies; or
4. Other organizations.

SECTION 8
CONTINUATION, CONVERSION, EXTENSIONS OF COVERAGE

8.1 Introduction

In some cases, a Member can choose to continue group Coverage for a period of time. In such a case, conversion Coverage would be available after group Coverage ends.

8.2 Continuation Coverage Under the Consolidated Omnibus Budget Reconciliation Act (COBRA)

Continuation Coverage under COBRA shall apply only to Employer Groups that are subject to the provisions of COBRA. Members should contact the Employer Group's plan administrator to determine if he or she is eligible to continue Coverage under COBRA.

Members who selected continuation Coverage under a prior plan which was replaced by Coverage under this COC shall be Covered until termination as scheduled under the prior plan or in accordance with the terminating events set forth below, whichever is earlier.

In no event shall the Plan be obligated to provide continuation Coverage to a Member if the Employer Group or its designated plan administrator fails to perform its responsibilities as defined by federal law. These responsibilities include, but are not limited to, notifying the Member in a timely manner of the right to elect continuation Coverage and notifying the Plan in a timely manner of the Member's election of continuation Coverage.

The Plan is not the Employer Group's designated plan administrator and does not assume any responsibilities of a plan administrator pursuant to federal law. For more detailed information concerning COBRA, the Member should contact the Group.

8.3 Continuation Coverage under Kansas State Law

Under Kansas law, a Member, who is an employee of a Kansas-based Employer Group or who is a Kansas resident, and was Covered by the Plan on the date of termination of Coverage may continue up to six (6) months of the Employer Group's current health care Coverage.

8.3.1 Qualifying Events for Continuation Coverage Under Kansas State Law

A Member is eligible for six (6) months of continued group Coverage if he or she meets all of the following requirements:

8.3.1.1 The Member has been Covered under this COC during the entire three (3) month period before termination;

8.3.1.2 The Member was not terminated for cause as permitted by the Group Master Contract;

8.3.1.3 The discontinued group Coverage was not replaced with similar group Coverage within thirty-one (31) days;

8.3.1.4 The Member is not and does not become eligible for Medicare Coverage; and

8.3.1.5 The Member is not eligible for any other Hospital, Physician and/or major medical Coverage for individuals in a group.

8.3.2 Notification of Requirements and Election Period for Continuation Coverage Under Kansas State Law

The Member must notify the Plan in writing if he or she elects six (6) months of continued Coverage. The Member must pay the first month's Premium within thirty-one (31) days of: (1) the date on which the Member's Coverage terminates

under this Agreement; or (2) the date on which the Member was informed of conversion rights from the Plan, whichever is later. Continued Group Coverage shall become effective the day following the termination of the Member's Coverage under this Agreement. Thereafter, the Member must pay monthly Premiums in advance to the Plan.

8.3.3 Terminating Events for Continuation Coverage Under Kansas State Law

Under Kansas law, the six (6) months of continued Group Coverage ends at the earliest of:

8.3.3.1 When the Member ceases to be eligible as defined above;

8.3.3.2 Six (6) months after the date the Coverage would have otherwise ended;

8.3.3.3 When the Member fails to make the required contribution on a timely basis; or

8.3.3.4 When the Member moves out of the Service Area.

Once a Member is no longer eligible to receive continuation Coverage, the Member is eligible for individual Conversion Coverage as described in this Section of the Agreement.

8.4 Individual Conversion Coverage

A Member who continues to reside within the Service Area may make application to the Plan for Coverage under a conversion contract without furnishing evidence of insurability, provided that the COC is still in force, that the Member has been Covered under this Plan during the entire three (3) months before termination and the Coverage terminates because:

8.4.1 The Member is not eligible for Continuation Coverage under COBRA or state Continuation benefits through no fault of the Member;

8.4.2 The Member who is a Covered Dependent ceases to be Eligible as a Covered Dependent; or

8.4.3 Continuation Coverage, as described above, is exhausted.

Application for direct pay Conversion Coverage effective on the date of termination, without furnishing evidence of insurability, must be made to the Plan within thirty-one (31) days after termination of Coverage under the COC. A conversion contract shall be issued in accordance with the terms and conditions in effect at the time of application and may be substantially different from Coverage provided under the COC.

Application to convert Coverage may not be made when Coverage terminates because the Agreement terminated and was replaced by similar Coverage under another group policy or Coverage under Medicare.

8.4.4 Exceptions for Conversion.

You will not be entitled to a conversion policy benefits if:

8.4.4.1 Termination of Your insurance under this Agreement occurred because You failed to make timely payment of any required contribution;

8.4.4.2 You had not been continuously Covered under the Agreement, and for similar benefits under any group policy which it replaced, during the entire three (3) months' period ending with such termination; or

8.4.4.3 The Agreement terminated or an employer's participation terminated, and the insurance is replaced by similar Coverage under another group policy within thirty-one (31) days of the date of termination.

You may not be entitled to renewal of conversion Coverage benefits as of any Premium due date for any of the following reasons:

8.4.4.4 Either the similar benefits for which You are or could be Covered, together with the converted policy's benefits, would result in overinsurance according to this Plan's standards for overinsurance, or You fail to provide the requested information;

8.4.4.5 You engage in fraud or material misrepresentation in applying for any benefits under the converted policy;

8.4.4.6 You are eligible for Coverage under Medicare or under any other state or federal law providing benefits similar to those provided by the converted policy; or

8.4.4.7 Any other reasons approved by the Director of the Department of Insurance.

8.5 Extension of Coverage if a Member is Confined

The Plan will continue to provide Covered Services if the Group Master Contract terminates while a Member is Confined. Services will be provided only for the specific medical condition causing that Confinement. This extension of Coverage will end on the earlier of the following dates:

8.5.1 The Confinement is no longer Medically Necessary;

8.5.2 The Member exhausts the Covered Services available for that Confinement and/or medical condition;

8.5.3 Thirty-one (31) days from the termination date of the Agreement.

SECTION 9
RESOLVING COMPLAINTS AND GRIEVANCES

A Member may occasionally encounter situations where the performance of the Plan does not meet expectations. When this occurs, the Member or Authorized Representative may call or write the Plan to file a complaint or an appeal. We will consider all the facts and handle all complaints and appeals promptly and fairly.

Please note that benefits are paid only if the services provided are Medically Necessary and are Covered Services under this Agreement.

9.1 Complaints

A complaint is an expression of dissatisfaction that may be resolved on an informal basis. Complaints may be expressed by telephone or in person and are handled by Our Customer Service Department. The Customer Service Department may involve one or more staff members of the Plan or Providers of health care before making a determination. The objective is to review all the facts and to handle the Complaint as quickly and as courteously as possible.

Written Complaints will be acknowledged in writing by the Plan within five (5) working days after receipt of the Complaint. The Plan will conduct an investigation within twenty (20) working days after receipt of the respective Complaint, unless the investigation cannot be completed within this time. If the investigation cannot be completed within the twenty (20)-day timeframe, the Member will be notified in writing by the 20th working day of the specific reasons for the delay, and the investigation will be completed within thirty (30) working days thereafter. The Member will be notified of the resolution within five (5) working days after the investigation of the respective Complaint is completed. Within fifteen (15) working days after the investigation of the respective Complaint is completed, the person, if other than the Member, who submitted the Complaint will be notified.

The address and telephone numbers for Complaints are:

Coventry Health Care of Kansas, Inc.
P.O. Box 7109
London, KY 40742
Telephone: (800) 969-3343

9.2 Appeals

If the issue in dispute relates to an Adverse Benefit Determination and the Member and/or the Authorized Representative are dissatisfied with resolution of the complaint or does not wish to first file a Complaint, he or she may file an Appeal. For Kansas-based Employer Groups, the Appeals must be made within one hundred eighty (180) days of the Adverse Benefit Determination.

The address for the Appeals Department is:

Coventry Health Care of Kansas, Inc.
Attn: Appeals Department
8320 Ward Parkway
Kansas City, MO 64114

You may ask Us to appoint a staff member to assist with the Appeal at any time during the process.

9.2.1 First Level Appeal

The Member or Authorized Representative may file a First Level Appeal by sending Us a letter describing the reason for the Appeal. For Appeals based in whole or in part on medical judgment, the First Level Appeal Committee will include a Medical Director and/or a Physician designee who have no prior involvement in the case and who are not subordinates of the individual who rendered the Adverse Benefit Determination. If the Medical Director and/or Physician designee are not in the same or similar specialty of the case under review, the Committee will also consult a health care professional who has training and experience in that field of medicine.

First Level Appeals are concluded as follows:

9.2.1.1 Urgent Care Appeals – First Level Urgent Care Appeals will be completed within 36 hours after receipt of the First Level Appeal request. We will notify Members and/or Authorized Representatives verbally and provide a follow-up written notice within 36 hours after receipt of the First Level Appeal request.

9.2.1.2 Pre-service Appeals – Requests for First Level Pre-service Appeals will be acknowledged by letter within five (5) working days of receipt of the First Level Appeal request. We will complete our investigation and notify Members and/or Authorized Representatives within fifteen (15) calendar days of receipt of the First Level Appeal request; however, with the Member's permission, We may delay the resolution of the First Level Appeal for thirty (30) calendar days if We have not received adequate information.

9.2.1.3 Post-service Appeals – Requests for First Level Post-service Appeals will be acknowledged by letter within five (5) working days of receipt of the First Level Appeal request. We will complete our investigation and notify Members and/or Authorized Representatives within twenty (20) working days from the date of the request for a First Level Appeal; however, with the Member's permission, We may delay the resolution of the First Level Appeal for thirty (30) calendar days if We have not received adequate information.

The Member will be notified of the resolution within five (5) working days after the investigation of the respective Appeal is completed. Within fifteen (15) working days after the investigation of the respective Appeal is completed, the person, if other than the Member, who submitted the Appeal will be notified. Our written notification to the Member or Authorized Representative will provide the reason for the decision. Our notice will give the Member or Authorized Representative instructions on how to proceed to a Second Level Appeal. If the Member or Authorized Representative is still dissatisfied with the decision, he or she may request a Second Level Appeal in accordance with the instructions provided in the notice. For Kansas-based Employer Groups, the request must be made within thirty one (31) calendar days of receipt of the First Level Appeal Committee's determination.

9.2.2 Second Level Appeal

The Second Level Appeal will be conducted by a panel selected by Us consisting of a health plan representative and other enrollees. In the case of Appeals based in whole or in part on medical judgment, the panel shall consist of a majority of

qualified health care professionals, which includes the written opinion of at least three (3) health care professionals who have appropriate training and experience in the field of medicine involved in the medical judgment. In the case of Appeals based in whole or in part on medical judgment, the panel shall consist of a majority of such qualified health care professionals. None of the committee members will be someone who made the Adverse Benefit Determination or was involved in the First Level Appeal, or who is a subordinate of someone who made the Adverse Benefit Determination or was involved in the First Level Appeal.

A hearing will be convened during a reasonable time period so that the Second Level Appeal can be concluded within the time periods specified below. The Member or Authorized Representative will be notified in advance of the place, date and time of the hearing and of the right to receive, free of charge, reasonable access to and copies of documentation relevant to the Appeal. We will hold the Second Level Appeal hearing during regular business hours at a location reasonably accessible to the Member or Authorized Representative. Any supporting material may be submitted before and at the hearing. The Member may also be represented by a person of his or her choice. During the hearing, the Member or Authorized Representative may ask questions of any panel members.

For Kansas based Employer Groups: In the case of Appeals based in whole or in part on medical judgment:

- the Member or the Member's Authorized Representative may, at their own expense, record the proceedings.
- the member may voluntarily waive the right to the second level of appeal. The waiver shall be in writing and shall constitute exhaustion of all available internal appeal procedures.
- At least one of the health plan representatives who will be deciding the second internal appeal or review shall be a physician who shall be present in person, by telephone, or by other electronic means.

Second Level Appeals are concluded as follows:

9.2.2.1 Urgent Care Appeals – Second Level Urgent Care Appeals will be completed within 36 hours after receipt of the Second Level Appeal request. We will notify Members and/or Authorized Representatives verbally and provide a follow-up written notice within 36 hours after receipt of the Second Level Appeal request.

9.2.2.2 Pre-service Appeals – Requests for Second Level Pre-service Appeals will be acknowledged by letter within five (5) working days of receipt of the Second Level Appeal request. We will complete our investigation and notify Members and/or Authorized Representatives within fifteen (15) calendar days of receipt of the Second Level Appeal request; however, with the Member's permission, We may delay the resolution of the Second Level Appeal for thirty (30) calendar days if We have not received adequate information.

9.2.2.3 Post-service Appeals – Requests for Second Level Post-service Appeals will be acknowledged by letter within five (5) working days of receipt of the Second Level Appeal request. We will complete our investigation and notify Members and/or Authorized Representatives

within twenty (20) working days from the date of the request for a Second Level Appeal; however, with the Member's permission, We may delay the resolution of the Second Level Appeal for thirty (30) calendar days if We have not received adequate information.

The Member will be notified of the resolution within five (5) working days after the investigation of the respective Appeal is completed. Within fifteen (15) working days after the investigation of the respective Appeal is completed, the person, if other than the Member, who submitted the Appeal will be notified. Our written notification to the Member or Authorized Representative will provide the reason for the decision. The written notice will also include information on applicable review processes available under state law. Members of Kansas-based Employer Groups will have the right to request from the Kansas Insurance Department: (i) an independent external review of the adverse decision after the Member has exhausted all Plan review procedures (or, an expedited external review in cases involving an Emergency Medical Condition); or (ii) an independent external independent review when the Member has not received a final decision from the Plan within sixty (60) days of seeking the Plan review (except to the extent the delay was requested by the Member).

9.3 Contact Information

You may contact the State Insurance Department at anytime by mail or telephone:
Kansas Insurance Department, 420 SW 9th Street, Topeka, KS 66612-1678 or toll-free at 1-800-432-2484

SECTION 10
GENERAL PROVISIONS

10.1 Applicability

The provisions of this Agreement shall apply equally to the Subscriber and Dependents and all benefits and privileges made available to You shall be available to Your Dependents.

10.2 Governing Law

This Plan is delivered and governed by the laws of the State of Kansas.

10.3 Limitation of Action

Members are encouraged to exhaust the Plan's Complaint and Grievance Procedure prior to pursuing legal action, (in a court or other government tribunal) as this is the most expeditious and cost-effective method of resolving Member concerns.

10.4 Nontransferable

No person other than You is entitled to receive health care service Coverage or other benefits to be furnished by the Plan under this Agreement. Such right to health care service Coverage or other benefits is not transferable.

10.5 Relationship Among Parties Affected by Agreement

The relationship between the Plan and Participating Providers is that of independent contractors. Participating Providers are not agents or employees of the Plan, nor is the Plan or any employee of the Plan an employee or agent of Participating Providers. Participating Providers shall maintain the provider-patient relationship with You and are solely responsible to You for all Participating Provider services.

Neither the Employer Group nor You are agents or representatives of the Plan, and neither shall be liable for any acts or omissions of the Plan for the performance of services under this Agreement.

10.6 Contractual Relationships

The Plan agrees with the Employer Group to provide Coverage for services to Members, subject to the terms, conditions, exclusions and limitations of the Agreement. The Agreement is issued on the basis of the Employer Group's Group Master Contract. This COC is issued on the basis of the Subscriber's enrollment in the Plan pursuant to the Group Master Contract in place between the Plan and the Employer Group, and the Employer Group's payment to the Plan of the required Premium. The Plan has the right to increase Premium rates, provided the Employer Group is given thirty-one (31) days advance written notice.

The Group Master Contract between the Plan and the Employer Group may require that the Subscriber contribute to the required Premiums. Information regarding the Premium and any portion of the Premium cost that a Member must pay can be obtained from the Employer Group.

This COC is part of the Group Master Contract as if fully incorporated into the Agreement, and any direct conflict between this COC and the Group Master Contract will be resolved according to the terms that are most favorable to the Member.

COC's will be provided to the Employer Group by the Plan for distribution to all Members.

10.7 The Plan is Not Employer

The Plan shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Employer Group's benefit plan. The Plan shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Employer Group's benefit plan.

10.8 Reservations and Alternatives

The Plan reserves the right to contract with other corporations, associations, partnerships, or individuals for the furnishing and rendering of any of the services or benefits described herein. The identity of the service providers and the nature of the services provided may be changed from time to time and without prior notice to or approval by Employer Groups or Members. You must cooperate with those persons or entities in the performance of their responsibilities.

10.9 Severability

In the event that any provision of this Agreement is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this Agreement, which shall continue in full force and effect in accordance with its remaining terms.

10.10 Valid Amendment

No change in this Agreement shall be valid unless approved by an Officer of the Plan, and evidenced by endorsement on this Agreement and/or by Amendment to this Agreement. Such Amendments will be incorporated into this COC. Amendments to the COC are effective upon thirty-one (31) days written notice to the Member or Employer Group. No change will be made to the COC unless made by an Amendment that is issued by the Plan. No agent has authority to change the COC or to waive any of its provisions. Copayment changes shall be made only on the anniversary date of the group's COC unless by mutual agreement of the Plan and the Employer Group.

10.11 Waiver

The failure of the Plan, the Employer Group, or You to enforce any provision of this Agreement shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of this Agreement shall not be deemed or construed to be a waiver of such default.

10.12 Entire Agreement

This Agreement shall constitute the entire Agreement between the parties. All statements, in the absence of fraud, pertaining to Coverage under this Agreement that are made by You shall be deemed representations, but not warranties. No such statement which is made to effectuate Coverage of a Member shall be used in any context to void the Coverage, with respect to which such statement was made or to decrease Benefits hereunder after the Coverage has been in force prior to the contest for a period of two (2) years during Your Lifetime, or unless such statement is contained in a written application signed by You and a copy of such application has been furnished to You.

Notwithstanding the Schedule of Benefits in this Plan, the Plan may provide different benefits to different Employer Groups or individuals, as determined by the Plan and applicable Employer Groups or individuals. Such differences in benefits shall be allowed only as the result of a written Amendment to the Agreement or similar document, approved by the Plan. The Employer Group will notify those Members affected by such different benefits.

10.13 Participation in Policies of The Plan

Any Member who wishes to participate in matters of the Plan's policies and operations may do so by submitting suggestions, in writing, to the Customer Service Department at the address located in the Schedule of Important Numbers.

10.14 Records

The Member shall furnish the Plan with all medical information and proofs of previous Coverage that the Plan may reasonably require with regard to any matters pertaining to this COC in the event the Plan is unable to obtain this information directly from the Provider or insurer.

By accepting Coverage under the COC, each Member, including enrolled Dependents, whether or not such enrolled Dependents have signed the application of the Subscriber, authorizes and directs any person or institution that has provided services to the Member, to furnish the Plan or any of the Plan's designees at any reasonable time, upon its request, relevant information and records or copies of records relating to the services provided to the Member. The Plan agrees that such information and records will be considered confidential. The Plan and any of the Plan's designees shall have the right to release, and secondarily release any and all records concerning services which are necessary to implement and administer the terms of the COC or for appropriate medical review or quality assessment.

10.15 Examination of Members

In the event of a question or dispute concerning Coverage for services, the Plan may reasonably require that a Participating Provider acceptable to the Plan examine a Member at the Plan's expense.

10.16 Clerical Error

Clerical error shall not deprive any individual of Coverage under the COC or create a right to additional benefits.

10.17 Notice

Written notice given by the Plan to an Employer Group, or an authorized representative of the Employer Group, is deemed notice to all affected Subscribers and their enrolled Dependents in the administration of Coverage under the COC, including termination of Coverage. The Employer Group is responsible for giving notice to Members.

10.18 Workers' Compensation

The Coverage provided under the COC does not substitute for and does not affect any requirements for Coverage by Workers' Compensation Insurance.

10.19 Conformity with Statutes

Any provision of the COC which, on its Effective Date, is in conflict with the requirements of statutes or regulations of the jurisdiction in which it is delivered, is hereby amended to conform to the minimum requirements of such statutes and regulations.

10.20 Non-Discrimination

In compliance with state and federal law, the Plan shall not discriminate on the basis of age, color, disability, gender, marital status, national origin, religion, sexual preference, or public assistance status.

10.21 Provisions Relating to Medicaid Eligibility

Payment for benefits will be made in accordance with assignment of rights made by or on behalf of a Member, as required by a State plan for medical assistance approved under title

XIX of the Social Security Act. To the extent that payment has been made under such State plan in any case in which the Plan has a legal liability under the Plan to make payment for such services, the Plan will pay for such services in accordance with any State law, provided that the State has acquired such rights to payment.

The fact that a person is eligible for or provided medical assistance under a State plan for medical assistance approved under Title XIX of the Social Security Act shall not be taken into account in enrolling such person, or in determining or making benefit payments under the Plan.

10.22 Policies and Procedures

The Plan may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this Agreement.

10.23 Discretionary Authority

The Plan has the discretionary authority to interpret the Agreement in order to make eligibility and benefit determinations as We may determine in Our sole discretion. The Plan also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive benefits under this agreement.

10.24 Third Party Service Providers

From time to time the plan may offer to provide Members access to discounts on health care related goods or services. While the Plan has arranged for access to these goods, services and/or third party provider discounts, the third party service providers are liable to the Members for the provision of such goods and/or services. The Plan is not responsible for the provision of such goods and/or services nor is it liable for the failure or the provision of the same. Further, We are not liable to Members for the negligent provision of such goods and/or services by third party service providers. Such discounts are subject to modification or discontinuance without notice.

SECTION 11
UTILIZATION REVIEW POLICY AND PROCEDURES

11.1 Utilization Review Circumstances

Utilization review is performed under the following circumstances:

11.1.1 Prospective or Pre-Service Review – Conducting utilization review for the purpose of Prior Authorization is called Prospective or Pre-Service Review. Services include, but are not limited to, elective inpatient admission and outpatient surgeries that require Prior Authorization.

11.1.2 Concurrent Care Review – Review that occurs at the time care is rendered. When You are hospitalized or Confined to a Skilled Nursing Facility, concurrent review is conducted on site or by telephone with the utilization review department at each facility.

11.1.3 Retrospective or Post-Service Review – Retrospective or post-service review is utilization review that takes place for medical services that have not been Authorized by the Plan, after the services have been provided.

11.1.4 Toll Free Telephone Number – The toll free telephone number of the utilization review department is listed in the Plan's Schedule of Important Telephone Numbers and Addresses.

11.2 Timing of Utilization Review Decisions

The time-frame for making utilization review decisions is as follows:

11.2.1 Prospective or Pre-Service Review – Two (2) business days from the date that the Plan receives all necessary information or fourteen (14) calendar days after the request for services, whichever is earlier.

11.2.2 Concurrent Care Review – One (1) business day from the date that the Plan receives all necessary information. The service shall be continued without liability to the Member until the Member has been notified of the determination.

11.2.3 Retrospective or Post-Service Review – Thirty (30) calendar days from the date that the Plan receives the request for determination. The Plan shall provide written notice of determination to the Member within ten (10) working days of making the determination.

11.2.4 In the case of an adverse determination for an initial determination and/or concurrent review determination, the Plan shall notify by telephone the provider rendering the service within twenty-four (24) hours of making the adverse determination, and provide written or electronic notification to the Member and the provider within one (1) working day of the telephone notification.

11.3 Reconsideration

You have the right to request reconsideration of any adverse determination involving a prospective or pre-service review as well as any concurrent care review determination.

Such reconsideration shall occur within one (1) working day of the receipt of the request and shall be conducted between the provider rendering the service and the reviewer who made the adverse determination or a clinical peer designated by the reviewer if the reviewer who made the adverse determination is not available within one (1) working day.

11.4 Right to Appeal

You also have the right to an expedited or standard Appeal. Please see the Complaint and Grievance Procedure Section of this COC for the time frames for Appeals. Reconsideration is not a prerequisite to any Appeal.

11.5 Denials of Claims

The Plan's Medical Director shall make decisions regarding the denial of care. Notices of claim denials shall include information regarding the basis of the decision and further Appeal rights.

SECTION 12
SERVICE AREA DESCRIPTION

Service Area

Kansas Service Area: The counties of Allen, Anderson, Atchison, Bourbon, Brown, Butler, Chase, Chautauqua, Cherokee, Coffey, Cowley, Crawford, Dickinson, Douglas, Elk, Franklin, Geary, Greenwood, Harper, Harvey, Jackson, Jefferson, Johnson, Kingman, Labette, Leavenworth, Lincoln, Linn, Lyon, Marion, McPherson, Miami, Montgomery, Morris, Neosho, Osage, Ottawa, Pottawatomie, Pratt, Reno, Riley, Saline, Sedgwick, Shawnee, Sumner, Wabaunsee, Wilson, Woodson, and Wyandotte.

Missouri Service Area: The counties of Andrew, Barton, Benton, Buchanan, Caldwell, Carroll, Cass, Christian, Clay, Clinton, Dade, Dallas. Daviess, DeKalb, Gentry, Greene, Grundy, Henry, Jackson, Jasper, Johnson, Lafayette, Lawrence, Livingston, Newton, Pettis, Platte, Polk, Ray, Vernon, and Webster.

SECTION 13
SCHEDULE OF IMPORTANT TELEPHONE NUMBERS AND ADDRESSES

Customer Service / Claims	**Prior Authorizations / Pre-Certification**
Coventry Health Care of Kansas, Inc. Customer Service PO Box 7109 London, KY 40742 (800) 969-3343 (866) 320-0697 (within Wichita) (866) 285-1864 TDD http://www.chckansas.com/	Coventry Health Care of Kansas, Inc. Customer Service PO Box 7109 London, KY 40742 (800) 969-3343 (866) 320-0697 (within Wichita) (866) 285-1864 TDD
Appeals and Grievance Coventry Health Care of Kansas, Inc. Attn: Appeals Department 8320 Ward Parkway Kansas City, MO 64114	**United Behavioral Health (UBH)** P.O. Box 30757 Salt Lake City, UT 84130-0757 (866) 607-5970 http://www.liveandworkwell.com
Kansas Insurance Department Kansas Insurance Department 420 SW 9th Street Topeka, KS 66612-1678 (800) 432-2484	

Authorization / Precertification List

As described within the Certificate of Coverage, certain services or procedures require authorization or precertification prior to services being performed. The following services or procedures require prior authorization or precertification. If you have any question, you may contact Coventry's Customer Service department for assistance.

- Hospital inpatient procedures / admissions
- Observation stays, medical / surgical
- Skilled nursing / extended care stays
- Chemotherapy
- Diabetic counseling
- Dialysis
- Home health care
- Hospice
- Hyperbaric services
- Implantable pain and insulin pumps, spinal stimulators and trials
- Rehabilitation, full- or partial-day
- Short term rehabilitation, including cardiac and pulmonary
- Specialized infusion clinics
- Transplants
- Wound care
- Durable medical equipment over $250
- Genetic testing / counseling
- Injectable medications
- Neuropsych testing
- Orthotics and prosthetics
- Physical / occupational / speech therapy
- Pain management (all services beyond initial evaluation)
- Sleep studies
- MRA
- MRI
- PET scans
- Nuclear cardiology / stress testing in an outpatient hospital setting **
- Cardiac SPECT scans in an outpatient hospital setting

** *These services do not require prior authorization when performed in the physician's office.*

Scheduled minor surgical procedures: The following services are usually performed in a physician's office. If any of the following are performed in an outpatient hospital or ambulatory surgery center, prior authorization or precertification is required.

- Skin lesions – Removal / Shaving / Biopsy
- Abscess / cysts – Incision and Drainage
- Nail removal / repairs
- Fine needle aspiration without imaging
- Ear wax removal
- Venous catheter maintenance
- Routine blood work
- Minor joint / muscle injections

Benefit Limitations: The following services require prior authorization or precertification as many of these procedures may be viewed as cosmetic surgery and/or may have certain benefit limitations or exclusions.

- Tummy Tuck / Abdominoplasty
- Eyelid Surgery / Ptosis repair
- Nose Surgery / Rhinoplasty
- Breast implant / breast reconstruction
- Breast mastectomy / reduction mammoplasty
- Experimental / investigational services
- Facelift / bodylift surgery
- Scar abrasion / revisions
- Liposuction
- Morbid obesity services
- Oral surgery / dental accident / dental services
- Pectus surgery
- Penile implants
- Laparoscopies/Hysteroscopies/Infertility services or procedures to promote fertility
- Varicose vein surgery / Sclerotherapy
- Tattoo removal
- Temporomandibular joint disease (TMJ) services
- Vision therapy - eye exercises

Note: The Plan reserves the right to modify this list or to exclude certain authorization requirements based on the Service Area.

APPENDIX A

MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFITS

ARTICLE 1 – Purpose and Function of This Explanation

This Appendix A is attached to and made part of the Coventry Health Care of Kansas, Inc. Certificate of Coverage (COC). The purpose of Appendix A is to explain Recognized Mental Illness and Chemical Dependency benefits provided by Coventry.

ARTICLE 2 – Definitions

Terms that are capitalized herein have the following definitions:

- Chemical Dependency: The psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.
- Community Mental Health Center: A legal entity certified by the department of mental health or accredited by a nationally recognized organization, through which a comprehensive array of mental health services are provided to individuals.
- Day Program Services: A structured, intensive day or evening treatment or partial hospitalization program, certified by the department of mental health or accredited by a nationally recognized organization.
- Diagnosis: The classification of a Recognized Mental Illness or Chemical Dependency through clinical assessment or laboratory examination.
- Licensed Professional: A licensed physician specializing in the treatment of mental illness, a licensed psychologist, a licensed clinical social worker or a licensed professional counselor.
- Medical Detoxification: Hospital inpatient or residential medical care to ameliorate acute medical conditions associated with chemical dependency.
- Nonresidential Treatment Program: A program certified by the department of mental health involving structured, intensive treatment in a nonresidential setting.
- Recognized Mental Illness(es): Those conditions classified as "mental disorders" in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, but shall not include mental retardation.
- Residential Treatment Facility: A facility licensed by the applicable state or approved by the Joint Commission on Accreditation of Health Care Organizations. The Residential Treatment Facility may be a general community Hospital with approved mental health beds, a psychiatric Hospital, a facility for the chemically dependent, or a Community Mental Health Center.
- Residential Treatment Program: A program certified by the department of mental health involving residential care and structured, intensive treatment.
- Social Setting Detoxification: A program in a supportive non-hospital setting designed to achieve detoxification, without the use of drugs or other medical intervention, to establish a plan of treatment and provide for medical referral when necessary.
- Visit(s): A session in an outpatient care setting in which the time frame is dependent on specific standard service codes used by the Licensed Professional.

ARTICLE 3 - Mental Health and Chemical Dependency Benefits

Subject to the Exclusions, Limitations, Deductibles, Copayments and Coinsurance described within the Certificate of Coverage, Schedule of Benefits and herein, Recognized Mental Illness

and Chemical Dependency benefits will be provided.

Covered Services are as follows:

A. Mental Health Benefits and Chemical Dependency.

- Inpatient treatment in a Hospital or Residential Treatment Facility is subject to the applicable Hospital Inpatient Copayment and/or Coinsurance as listed in the Member's Schedule of Benefits. Inpatient treatment is covered up to sixty (60) days per Calendar Year.
- Outpatient treatment, including treatment through partial or full-Day Program Services is covered in full for the first three (3) Visits. The subsequent twenty-two (22) visits are subject to a $25 Copayment and any additional visits will be subject to 50% coinsurance.
- Coverage will be provided for Biologically Based Mental Health Conditions is provided on the same basis as any other medical conditions.

B. Coinsurance Maximum. Copayments and/or Coinsurance paid for Mental Health and/or Chemical Dependency do not apply towards the Member's Coinsurance Maximum limit as defined on the Schedule of Benefit.

ARTICLE 4 - Limitations and Exclusions

A. The following types of treatment are excluded:

- Services for mental retardation and disorders after diagnosis and relating to: learning, motor skills, communication, feeding and eating in infancy and early childhood;
- Relational problems, anti-social behavior, academic problems and phase-of-life problems;
- Vocational, marriage and sex counseling, acupuncture, biofeedback, hypnotherapy, sleep therapy, vocational rehabilitation;
- Individual treatment for smoking cessation, weight loss, or personal growth
- Services that are court ordered in connection with divorce, child custody, child visitation proceedings, or a condition of parole or probation;
- Services and supplies for Custodial Care including but not limited to those primarily to maintain activities of daily living, self care and safety of the patient; and
- Services provided for the treatment of conduct disorders including but not limited to Residential Treatment Programs, inpatient and/or outpatient coverage.
- Services rendered or billed by a school or halfway house.
- Services and supplies that are not immediately nor clinically appropriate.